Mental Health Medication Advisory Committee Meeting Meeting Minutes, Open Session February 14, 2017 at 2 pm – 4:30 pm		
MHMAC Meeting Minutes Open Session HP Enterprise Services Capital Room 6511 SE Forbes Ave, Topeka, KS 66619	**Members Present:** Susan Mosier, Secretary of KDHE, MD, MBA, FACS (Chair) Vishal Adma, MD, MS, CMQ, CPE Nicole Ellermeier, PharmD Rebecca Klingler, MD Karen Moeller, PharmD, BCPP Charles Millhuff, DO Taylor Porter, MD **Members Absent:** Ashley Goss, Interim Deputy Secretary of KDHE (Appointed Temporary MHMAC Chair) Holly Cobb, NP Brad Grinage, MD **KDHE Staff Present:** Annette Grant, RPh, KDHE/DHCF Carol Arace, KDHE/DHCF **MCO Representatives Present:** Jennifer Murff, RPh – United Healthcare William Mack, MD – Amerigroup Lisa Todd, RPh, BBA – Amerigroup Angie Zhou, Pharm. D. – Sunflower Katherine Friedebach, MD-Sunflower **HP/HID Staff Present:** Nancy Perry, RN Karen Kluczykowski, RPh Ariane Casey, Pharm. D. (phone)	**Representatives:** Bret Moehlman, Ison Mnt; Diana Toe, Sunflower; Sara Schenkilping, MedTrak; Roy Lirdfield, Sunovian; Christopher Berl, Otzuka; Sue Lewis, Mental Health; Kristin Parjir, Mental Health; Rick Kegler, Mental Health; Jonalan Smith, Sunflower; Terry McCurren, Otsuko; Ri Orngi, NAMI; Jennifer Stoffel, Janssen; Mary Jo Deflorio, J & J

	DISCUSSION	DECISION AND/OR ACTION
I. Call to Order A. Introductions B. Announcements	**[09:45] Call to Order:** Dr. Mosier: We'll call the meeting to order. I did have a request from last time, so I'm hoping that I'm projecting well. I'm looking at the room to see. We do want speak more loudly for everyone in the room to hear. Perhaps next time we'll be able to get some additional microphones or something to assist. The other thing is sometimes we speak in technical terms, so if we can translate it to English, that would be perfect. Okay? Thank you very much. We talked about last time that we were going to change the order up a little bit and we'll do Old Business and then we'll go to Process Improvements and specifically talk about the Prior Auth process today and then go to New Business. That will allow us time. The last couple of times we haven't been able to get to the process piece and we do want to get to that today. I know that not everyone in the room knows everyone here. As an Ophthalmologist, this might not be big enough for some people to read in the room. We will just go around, starting this way, and introduce yourselves and who you're with. **Introductions:** Dr. Adma: Vishal Adma. Board certified Psychiatrist. Medical Director for KVC Hospitals Inc. as well as past president for Kansas Psychiatric Society. Dr. Friedebach: I'm Katie Friedebach. I'm a family Physician and I'm the Chief Medical Director of Sunflower Health Plan. Dr. Zhou: My name's Angie Zhou and I'm the Pharmacist for Sunflower Health Plan. Dr. Murff: I'm Jennifer Murff and I'm the Pharmacist for United Health Care. Dr. Klingler: I'm Becky Klingler and I'm a Pediatrician in Manhattan and that's about it. Dr. Moeller: I'm Karen Moeller. I'm a Pharmacist also board certified in Psychiatric Pharmacy and I work with the University of Kansas.	Sec. Mosier called the February 14, 2017 MHMAC meeting to order at 2:04pm.

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	Dr. Millhuff: Hi, Chip Millhuff, I'm a Child Psychiatrist. I work at Family Service and Guidance Center here in Topeka. Dr. Mack: Bill Mack, I'm a Behavioral Health Medical Director for Amerigroup of Kansas. Dr. Todd: Lisa Todd, Pharmacist with Amerigroup. Ms. Grant: Annette Grant, Pharmacy Program Manager with KDHE. Ms. Arace: Carol Arace, Administrative Assistant with KDHE. Dr. Ellermeier: Nicole Ellermeier, Pharmacist at MedTrak. Dr. Mosier: I'm Susan Mosier, Secretary of KDHE and Chair of the Committee. Also an Ophthalmologist by training. **Announcements:** Dr. Mosier: I did want to say; Dr. Grinage will not be able to join us today. He is out with the flu. I want to make a reminder for everyone in the room that the Committee is made up of Pharmacists, Psychiatrists, and Clinicians. We do have our managed care Pharmacists and Medical Directors here, but they're here for advice only. There're not members of the Committee. Just to remind everyone in the room of that.	
II. Old Business A. Review and Approval of November 30, 2016 Meeting Minutes	Dr. Mosier: We'll start with Old Business and the *Review and Approval of November 30, 2016 Meeting Minutes*. If anyone has any corrections changes or updates to any of those? Dr. Adma: I move there are no changes. Dr. Moeller: I second. Dr. Mosier: Very good. Moved and seconded that we approve the minutes. All in favor say 'Aye'. {Many Aye's are heard}	Dr. Adma moved to approve the minutes as written. Dr. Moeller seconded the motion. The November 30, 2016 minutes were approved as written unanimously.

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	Dr. Mosier: Any opposed? {Silence} Dr. Mosier: Alright. **Committee Discussion:** None.	
II. Old Business B. Prior Authorization Criteria 1. Antipsychotic Dosing Limits <18 years old	**Clinical Public Comment: -** No requests were received. Dr. Mosier: We will move on to Old Business. *The Prior Authorization Criteria*, starting with *Antipsychotic Dosing Limits <(less than) 18 years old*. Annette if you would go through what the updates were on this. Ms. Grant: Sure. Ok. A couple of things. If we just start from top to bottom. We did not have the less than 18 years before, we had 13 and under, I think. Based on the decisions that were made last time, I thought we'd change the title to be less than eighteen years, because that's the dose range we're giving limits for on this. Maybe the first thing we want to discuss is if that's the new title? **Committee Discussion:** Dr. Mosier: These were conforming changes, right? We talked about? Ms. Grant: Right. We talked about dosing and then coming back with the final form and voting on all the dose changes based on everybody's input. I updated the document to reflect that. Therefore less than 18 would be the appropriate title for this document. Dr. Mosier: Are there any other changes in the document? Ms. Grant: Yes.	A voice vote was taken for title change to less than 16 and changes to the dosing table's column headings to be 4 years to less than 6, 6 to less than 10, 10 to less than 16, and then for reference, have the adult dosage. The above points were approved unanimously by voice vote. Maximum dose ranges were tabled to the next meeting.

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	Dr. Mosier: Let's go through each. Ms. Grant: The first thing is that we did talk about Aripiprazole having a starting dose and maximum dose. The problem with having a starting dose is that the MCOs might not be able to operationalize this piece. I don't know if we just want to put a maximum dose there, because we could put in edits for maximum dose. Abilify/Aripiprazole is one of the drugs that can be used for under six. And then there's, based on input from the group the last time and between then and now, I put dosing in these different boxes based on recommendations from members of the [Committee]. So, I guess, if you would go through the dosing on there? The next one I want to bring your eye to is [inaudible][15:38]. Some of the first generation antipsychotics do have some child doses that are being used out in the field. The question is; well, going back to last meeting, do we want to promote that by having a does or go ahead and put doses on there because they are being used out in the field? So, that would be a question for discussion. Haloperidol is another older one that they have a dose for younger ages. Which we did not discuss last time what that dose was, but we've gotten input from those who are using it and the dose range that they are using. Then you will see other; the ones highlighted in yellow are the ones that I didn't get doses from anybody from the [Committee]. But there was; I put the facts and comparison dosing in and/or not approved at all if they didn't have a dose. Those are the highlight ones that I just inputted based on facts and comparisons and input the number there. We could always put 'not approved' or if somebody's come up with something since then. Dr. Adma: So last time you submitted for all of these, I think, or in case most of them, the starting doses and the maximum doses as per the discussion from Texas and other research from other states, right? Can you hear me? Looks like people. Unknown: No. Dr. Adma: Okay. Let me speak up. Unknown: If you could project. Dr. Adma: Sure. So last time…	

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	Unknown: Thank you. Dr. Adma: … I thought that you put forward a proposal for consideration where, I think from Texas… Dr. Millhuff: Correct. Dr. Adma: …or other states, where you researched and came up with starting doses and maximum doses for these medications. Dr. Millhuff: The only starting doses I proposed were for Risperdal and Abilify and I believe those are on there. Ms. Grant: Yes. Dr. Millhuff: But, as we had discussed last time, it sounded like it was going to be very difficult to implement. I didn't put any more effort into defining those for today. I just thought we would just stick with the maximum dose for now. Dr. Adma: Okay. Ms. Grant: Just to clarify, we originally had the Texas information then I think you came back and we decided to put the Florida information in there for the dosing. Dr. Moeller: I think for children less than six we used the Florida. Is that correct? Dr. Millhuff: There's some differences of numbers there. Ms. Grant: It was all of them. Whatever Florida had is what I thought I was told to go back and put the Florida dosing in. Dr. Millhuff: Right and I went through all of that and contrasted it to the Texas information; sent you some information. I also just simply checked on the FDA prescribing information, approved	

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	prescribing information; for a number of these medicines. And the way we have it set right now, Annette, is I think the dosing numbers are good. The only thing that I would suggest to the committee to consider is lowering the age from; changing the age brackets a little bit. Rather than from 12 to less than 18, I'd recommend 10 to less than 18. That's primarily based on the FDA approvals for these meds, a number of them. Because a lot of the Bi-Polar studies in adolescents are defined from 10 to 17 years of age. The way we've got our format now, we have dosages that are lower for kids younger than 12 that the FDA says we can use a higher dosage in that age frame. If we just widen our parameter for adolescents a little bit wider, we'll be more in line with a number of the meds that are used really these days and are FDA approved for that age range for 10 to 17-or less than 18. That was one of the primary things I sent you. Ms. Grant: Right. Right. Dr. Moeller: I don't know if this is the time. I don't mean to interrupt, but I do have some concerns with the 10 to 18 or 12 to 18, however we're going to define it, that we have not FDA approved does that mean they can't be prescribed? Because I do have, you know, a 17 year old, 15, 16 with psychosis they may want to put them on a; maybe a 17 year old on Haldol Decanoate. I don't know, I just want to make sure we're not limiting some of these drugs. So, I didn't remember if that was the case. Ms. Grant: I think that would go to manual PA then. I'm thinking that anything that is not on this would go to that. Dr. Moeller: Okay. Dr. Millhuff: So, I specifically asked prescribers within the mental health agencies as well as I sent to the psychiatrist as a part of the Kansas City… or the American Academy of Child and Adolescent Psychiatry's more regional group, all of them, and I asked specifically: 'Are people using long acting injectables and if so, which ones are you using?'. The two that I heard repeatedly were the newer two that are on our list here. The Maintenna and the other one. Dr. Moeller: Invega Sustenna.	

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	Dr. Millhuff: Sustenna, correct. Those two, just nobody mentioned anything older. But, you know, I understand what you're saying. Dr. Moeller: I just had some concerns, I mean, [inaudible][21:50], I see even like Loxapine is not FDA approved. But I used to see, like, using a lot of people with intellectual disabilities, I've seen that drug. So, I think, one thing we need to definitely, we need to look at that 18, the 12 to 18 years of age, and make sure we're not limiting it too much, I think. Ms. Grant: Do you have a dose you want me to put in for Loxapine? Dr. Adma: That's the next one. So, I guess the thinking there is, if it is not FDA approved, do we want to limit prescribers from not prescribing unless it hits the prior authorization? That's the question, I guess, right? Dr. Moeller: Because I think we'll get, like when we hit the anti-depressants too. You would only for depression, you know, prescribe two drugs, like, two SSRIs for depression. Are we wanting to limit based on indications? Dr. Adma: So, Dr. Millhuff, are you thinking, you know, do we want to go with the FDA indication only or based on the clinical practice that generally accepted practice? Dr. Millhuff: I think both. I mean we shouldn't certainly limit it below what the FDA's approved. But I think that the feedback that we've received and some of the consensus from other systems, mention higher doses, or doses for drugs that are FDA approved. I don't know what to say to your question, Karen, about the older, like, Haldol Decanoate, I don't. Dr. Moeller: And I don't know either. But you know, I look at… you know I look at even the Aristada, I don't have much. I haven't seen that used, but I do see some people are using it because you can dose it every six weeks versus every four weeks with the Maintenna. I think, right now that's probably a 'which one is going to win out'. What prescribers use, I think it's so new. By us saying the Maintenna and not the Aristada, we're kind of making formulary, you know. I don't have any problem if we do that. I just want to make sure, we're not limiting, you know, like,	

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	Brexpiprazole or Cariprazine if somebody fail. I'm thinking maybe the older; 15, 16, 17 year old maybe. I don't think we should start with those but if someone's failed multiple if, you know, I just want to make sure we don't limit it too much. Yeah, you're probably right. We probably don't use the Haldol Decanoate for young kids. I'm thinking even you said 10 to 18; maybe it should be like 10 to 15 and then consider 15 and up or 16 and up because it's such a; they're starting to have adult pharmacokinetics characteristics but they are still children. So, probably rely on your expertise, Dr. Adma, such as, how do you treat those 17 year olds, 16 year olds? Do you use similar dosages to adults? Dr. Millhuff: I had one prescriber mention, I don't even know if I'm saying it right, Rexulti, one say; 'What if I wanted to use this in a 16/17 year old who clearly has schizophrenia? There's compliance issues.' but then he said; 'I haven't used it with anyone.' And, so, I guess what I was trying to do is represent sort of the community standard as to what has been going on in our state. I certainly gave a lot of people the opportunity to speak up and say whether or not they're using any of these. And it was really very few. But if it is a psychiatrist that is prescribing this, wouldn't they have authorization to go ahead and use it without review anyway? Dr. Mosier: Right. Dr. Ellermeier: So I think one of the things I'm kind of feeling like if we limit it to, like if it's their 18th birthday and older and we say that's the cut off for adult dosing, I feel like that is too old. I'm kind of in agreement with Karen that maybe it's a little bit younger than that. 16 or 17 that we start to allow adult dosing if needed. So maybe it's a matter, even down to their 17th birthday, that the adult dosing applies. And then we could do 10 to 17 and then 17 and above is the adult dosing to just tweak it a little bit to give that flexibility and, you know, as kids start to get a little bit older and more like adults. Dr. Moeller: I was going to say even the Consta too, before Invega came out, there were a lot of children getting that drug too in the 16/15 year old. Sustenna seems to be the one now we're all using. Dr. Mosier: But I think the thing to keep in context here is that you're talking about that this doesn't apply to the psychiatrist, right, so you can do that anyway and then you're looking at for someone	

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	who is not a psychiatrist prescribing that would go through a PA process. So, not everyone who's under 17. I personally feel much more comfortable leaving it. This is what we found from other states and doing a survey, right? This was Florida? This was Texas? Ms. Grant: This was the common theme with these doses and age brackets. Dr. Adma: Annette, if today, if this goes into effect, do you have any numbers as to how many? What are we talking about? Is it a lot of prescribers out there who might fall into that category of pre-authorizations? Ms. Grant: Well, it's a couple things. It was hard to bring data for today because we didn't know which age brackets. It hadn't been voted on yet. I do have how many kids are on each kind of drug but it wasn't the total milligrams used, it was just the drug name. Dr. Adma: Because, at least, based on what it looks like there might be multiple reasons for this to be hitting PA at some point whenever this goes into effect if we were to approve this, right? Ms. Grant: Right. Dr. Adma: So, we just want to, at least, know, again, discounting that there are a lot of board certified psychiatrists who may not even hit this, but again, based on the data that we know, at least 60% of the PCPs prescribe most of the psychotropic medication. Right? Ms. Grant: [Yes.] Dr. Millhuff: The other challenge is what I've heard repeatedly from people, is patients coming out of the hospital. Where they're having their medicines managed by primary care or maybe someone who doesn't have this preferred prescriber status and the antipsychotic is being stopped at the pharmacy. Sometimes people going more than a week without their medicine and falling apart. Destabilizing emotionally. That's a big concern from what I see with some of the hard stops with this. Dr. Moeller: I guess as we're reviewing this with the 18, it really seems to be mainly all the	

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	Decanoates. So maybe that's something we might want to visit. I forgot about, you know, about having the green card, or what we call it. So I do, I think, you know, the primary care physician is prescribing this and not us; I don't mind them getting a, having to get an approval or going to a psychiatrist, you know, adolescent. Dr. Ellermeier: I have a question. So, we changed the title of this to *Dosing Limits in Children*, but the last column is the adult dosing, is that just housed in a separate…? Ms. Grant: I wanted to take it off but then… Dr. Ellermeier: For reference? Ms. Grant: I thought it would be a good reference. So whatever you guys decided is fine with me, but I was asked both ways. So we can definitely vote on that today and what you would like. Dr. Ellermeier: The adults are just; they're in a separate; they're adult dosing limits even though we are changing the title of this, they're just separate, so this is more for reference? Ms. Grant: Yes. Dr. Ellermeier: That makes sense. Dr. Mosier: We could put that on the column title; 'For Reference' and then that way it's very clear that that's why it's provided. Dr. Adma: At least let's focus on, Karen, let's focus on the Deconoids. So what is the committee thinking? Any thoughts on what we should do because none of the Deconoids are FDA approved, right? Dr. Moeller: I guess that would; now that I think about it, you know, I would want, if they're on Decanoate, I would really want an adolescent psychiatrist or a psychiatrist prescribing that versus… Dr. Adma: So it's from the committee standpoint we're thinking it might be safer practice that the	

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	Decanoates need to be pre-approved or go through prior authorization if a PCP or Nurse practitioner is prescribing it. Is that safe to say? {Several speak softly in agreement} Dr. Porter: That's in adolescents? Dr. Adma: Yes, this is 18 or less. Now, 18 or less meaning 18 included or not included? Ms. Grant: The way the bracket is 12 to under 18. Dr. Adma: Under 18, okay. So, it's 17. So once they hit 18 it changes. Ms. Grant: They're basically like an adult. Dr. Porter: I think it would be uncommon in that age group range. The only thing I would say is we don't have representation from some of the more rural mental health centers. I know that this is in the adult mental health center here in Topeka and it's got 95% nurse practitioner, DNP, doctor/nurse practitioner prescribing. That wouldn't affect this directly, but I don't know what, say High Plains, or more rural; there might be more rural mental health centers, that their psychiatric practitioner is only a nurse practitioner and they don't have child; only Shawnee County has these in separate entity, adult and child, so… Dr. Adma: So at KVC we get a lot of kids from High Plains, now that you mention High Plains, and in the last 6 years we've had maybe one kid on Decanoate. Dr. Porter: Yeah, it's uncommon. Dr. Moeller: Now I do want to just want to make sure, there are recommendations for the Paliperidone, Invega Sustenna decanoid, and the Abilify Maintenna decanoid. So was that just based on what people in the community used? Dr. Millhuff: Right.	

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	Dr. Moeller: But they are also not FDA approved. Dr. Millhuff: No, but that's what I heard from… Dr. Moeller: See then we are kind of making a recommendation that those are the preferred drugs, the preferred decanoids. So, you understand what I'm saying? So if someone wants to prescribe, we're going to be saying, you know, a decanoid, we're going to be saying these are on formulary, Invega, so we are kind of endorsing those. Dr. Ellermeier: Even between products, like Invega Sustenna, we have a dose, but not the Invega Trinza and the Abilify Maintenna over Aristada. Dr. Moeller: And the Risperidone Consta, you know, Invega is the tablet over Risperidone, so do we want all decanoids to be… Dr. Adma: Listed separately, you're thinking? Dr. Moeller: Listed separately or do we want all decanoids needing prior authorization or do we put doses for all decanoids or do we just do the atypicals? Do you know? Dr. Adma: I would put all decanoids requiring prior authorization if it is less than 18. I think that might be a safer route. Dr. Millhuff: Vishal, I talked with Mark Romereim out in Great Bend, I believe, he is a general psychiatrist working with pediatric patients. Very experienced psychiatrist. He told me 'I've got 11 kids, right now, on long acting injectables.' The two that we've been talking about. So, Mark would not be able to… Dr. Adma: He's a board certified. Dr. Millhuff: He *would* be able to, in pediatrics?	

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	Dr. Adma: Yes. Dr. Moeller: It's any psychiatrist, correct? Not just… {Several say 'board certified' at the same time} Dr. Porter: The question had to deal with DNP and nurse practitioners. Dr. Millhuff: Okay, that's right. Dr. Porter: They would need to go to prior auth. Dr. Adma: But in thinking, if they are collaborating with a psychiatrist, they can put the name of the psychiatrist if they are working with a psychiatrist, right? Dr. Porter: Well they have to, in this state, they have a collaborative agreement, so they would have a psychiatrist or they wouldn't be able to prescribe. I just stepped in late, so I don't have any idea if this would affect delivery of care in some place that didn't happen to have a psychiatrist at their mental health center. Dr. Moeller: Well, they would still be able to get the oral. So that would be one nice thing. We wouldn't be limiting. They would be able to get the oral. That was some of my concern was having some of these, you know, 'not FDA approved' or we wouldn't recommend it, that there could be a delay. But with the Decanoate, they still could get the oral in the process. So that's one nice thing. Dr. Ellermeier: So I have a question just about how the drug is billed and administered. Are those centers, like if they're starting a patient on one of those long acting; are they doing that while the patient is there, discharging them, then going to the pharmacy for their next fill or are they always filled through the pharmacy? I'm wondering if it will actually be stopped at a pharmacy to start them on the medication or not. Dr. Moeller: I think it differs. Because I know when we discharge people, adults, we send it to a pharmacy and it gets billed through the pharmacy. And like at the department of mental health	

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	center, the nurses just pick it up there and administer. Dr. Porter: Is the question; let's say they see the provider, they leave the office, they've got their prescription, and they're out of our office and now they can't get their prescription and it's the end of the day. Is that it? Dr. Ellermeier: So are they going to administer that medication at home or is it going to be administered at the office? So is it going to be administered from office stock or through pharmacy stock? Ms. Grant: So that would be KB. Dr. Ellermeier: Right, I'm wondering if it would even hit at the pharmacy. Dr. Porter: We had a lot of this at Valeo. They're filled at the pharmacy and then brought back to nursing staff. Dr. Moeller: We will sometimes send them to, like our outpatients, we'll get them at the pharmacy and they'll walk up to get their injection. Yeah, I was thinking that too. But I don't think a lot of people do it as office stock. Dr. Porter: No. Ms. Grant: It most likely be done [inaudible][38:21] transition to IM. So then that should be plenty of time to get the IM approved. It would be approved based on the fact that they already have been on… Dr. Moeller: The problem is, you know, when they are in the hospital, we may give them a dose and then maybe we'll send them out. It should have been checked beforehand that their insurance will pay for it; that there's not going to be any prior auth, that could be, you know, when they're transitioning to the outpatient. So. Dr. Porter: What's the thought about restricting from nurse practitioners? What's the safety	

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	concern? Dr. Mosier: Well, that will be a separate discussion about kind of the process. We're not folding that into these criteria. Dr. Porter: The specifics of the criteria. Dr. Mosier: Yeah, that's a separate [discussion]. Dr. Adma: So going back to the Decanoate, are we okay saying that the psychiatrist-board certified psychiatrist, child psychiatrist, can prescribe without PA and then PCPs, non-board certified psychiatrists, they need to have a prior authorization to prescribe. They can still prescribe; they just need a prior authorization. Dr. Ellermeier: I think I would agree with that especially because, given the fact that these patients are going to be on oral medications before their transition, so there should be a period where that's happening anyways, so it wouldn't be a hard stop-it shouldn't be a hard stop with their medication. Dr. Moeller: And I would think that if they were started in the hospital, it would be prescribed by a psychiatrist. I would think they would be in a psychiatric hospital that would write the prescription on discharge. Dr. Adma: Okay, so let's focus on the oral medications. On the oral medications there are some yellow… Ms. Grant: Dr. Adma? Do you want me to; are you saying on all the extended release, the IMs that I need to put 'not approved' then? Is that the concurrence? Dr. Millhuff: I liked what you said a moment about bringing our top age limit down a little bit. If we just moved everything down. Say 10 to 16 and call it good across the board, then we've got those older adolescents, that are very unstable, and all of these adult dosages would be available to them for all of these. All the Decanoates, long acting injectables. That approach appeals to me. It's simple. Anything below 16; anything below for the injectables would not be approved.	

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	Dr. Adma: Have the other states done something like that, Chip? Because most of the states stick with 18. Dr. Millhuff: Right. I know. But when you think about Texas, this is a trigger for a review; it's not a trigger for a PA process. As you mentioned earlier, Dr. Mosier, in our earlier meeting, we're just trying to set the bumpers out there so that it's generally safe. I think that that would do that and do this fairly well. I think that, you know, tighter range of numbers and, kind of like what we're weighing here, would be more appropriate if it's a trigger for a consultation or discussion about 'what are you doing?' Just to reiterate, a number of people have told me it's this age range between 10 and 12 and then the age range between 6 and 18 that they are wanting to use a little bit higher dosages than what we had outlined in our format. So I think this shifting it down would suffice for it. Dr. Porter: Did you mean between 6 and 18 or between 16 and 18? Dr. Millhuff: No. Changing from 12 to 18 to 10 to 16. Dr. Moeller: Then 6 to 10. Dr. Millhuff: So just basically moving it down one to two years. Dr. Porter: Thank you. Dr. Ellermeier: I think you thinking of what we are trying to accomplish. We're trying to set some bumpers of what is generally safe. I think we're all a little more comfortable the older a child gets to like 16/17 years old, treating them more like an adult. Rather than, I think it's finding a balance of limiting, you know, if we potentially limit access versus safety. I feel comfortable lowering that age threshold a little bit to account for some of the unique challenges we have in this state with the rural setting. Dr. Moeller: I think we can still have the guidelines, you know they need to have that yearly physical; they still need those metabolic parameters with it. I feel more comfortable too. I just, I	

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	worry about those 17 year olds because there can be some really psychotic 17 year olds. First break schizophrenia happening at 17. I just, I hate to limit an option. But I think we're doing a great job, we have these adult doses; we have a lot of things in place. But I would still maybe go down with the parameters come up with the metabolic monitoring, keep them but maybe allow them to do the adult dosing. Dr. Adma: So I agree with the idea the only thing is, because nobody in the county is doing this, the committee is thinking we should go in this direction. Dr. Millhuff: Vishal, I don't know if I'm communicating this very clearly, if I understand it correctly, Florida, Texas, other states make it very explicit. This isn't a hard stop. This is a trigger for discussion about 'what are you doing with the dose'. So I think that's what makes this a little bit different here with what we're doing. Dr. Adma: Sure. I completely agree. That's all I'm saying is we probably need some kind of rational. The discussion in the minutes might be sufficient enough or something like that, right? Dr. Millhuff: If we're down the road in this meeting talking about changing the way we monitor this with alternatives besides just a PA at the pharmacy stop, then I think I would be more open to falling in line with what other states are doing as the examples of what we've been looking at. Dr. Adma: Okay. Dr. Mosier: So on that particular one, it sounds like max daily dose 6 to less than 10 and then the proposal on the table is 10 to… is it less than 16 or less than 17? Dr. Millhuff: I'd say 16. Dr. Moeller: So when you say less than 16… Dr. Ellermeier: So on their 16th birthday, they are adult for dosing. Ms. Grant: So [inaudible][45:35] doses with those new age brackets?	

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	Dr. Moeller: So then I would say we have to take Abilify Maintenna we would have to say 'not FDA approved'. Dr. Ellermeier: I'd agree. Dr. Moeller: And do the same with Paliperidone palmitate. Dr. Millhuff: That would make sense. [46:06] Dr. Porter: I guess the other confusion I would have: we've got some things that are FDA approved that aren't FDA approved that we give dosing limits, and some things where we simply say not FDA approved? Dr. Moeller: That's kind of how we started. Dr. Porter: Maybe, just for accuracy, maybe if it's not FDA approved and we want to put dosing limits on it we could just put both of those in the box instead of making it sound like it's FDA approved when it's not. Dr. Ellermeier: Or like some sub-note that says like basically this is a recognized dose. Dr. Millhuff: Supported by evidence based practice. Dr. Ellermeier: Yeah. Generally recognized in practice. Something to denote that it's not FDA approved. Dr. Porter: To read this, if you're not in this every day, it looks like everything on here is FDA approved or not FDA approved and that's not the case. Ms. Grant: Should we put 'not approved' on them versus 'not FDA approved', just put 'not approved'?	

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	Dr. Adma: Or do we put 'Does not require prior authorization' or 'Does require prior authorization'? Or 'Requires PA'? Dr. Ellermeier: Requires PA. Dr. Adma: Requires PA. Dr. Moeller: Under 6 years of age-not approved. Dr. Millhuff: So Texas puts 'insufficient evidence'. That's what they put. Or they put 'not approved for children or adolescents'. Dr. Adma: Or 'Requires PA'. It can still be approved, right? Ms. Grant: I think that sounds… Dr. Ellermeier: Yeah, 'Requires PA', I think is more accurate. Dr. Millhuff: Sounds good. Ms. Grant: On all of them? On everything? Dr. Porter: I think it's just a wording thing. But we've got 'approved' and using it two different ways. Committee approved versus the FDA approval process. It makes for an inconsistent document. I think we should just clean that up. Ms. Grant: Okay, so everything that says 'not FDA approved' I'll just put 'Requires PA'? Dr. Adma: Requires PA. Ms. Grant: I'll fix that later, I don't want to take time for that now, but I'll do that.	

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	Dr. Todd: Can I ask an operational question? Ms. Grant: Yes. Dr. Todd: So when we're saying that they're 'Required PA' what are we wanting that claim to do for those members of that age for that drug? Ms. Grant: So you need some information that says what now makes it approved versus still not approved? What are the criteria for it? Dr. Todd: Or are you just not going to cover it? Dr. Ellermeier: I think it would be the criteria that's on like the first page that they 'anything exceeding what's listed in table one will require PA', and then it's 'prior authorization requires a peer-to-peer consult'. Unless we want to change how that looks but I think it would be that. That is what would have to be met for anything above this or anything that says 'Requires PA'. Dr. Todd: So it would just be a peer-to-peer, so 'Require a peer-to-peer-to-peer'? Is that? I'm moving a little slow. Dr. Ellermeier: So if it's something that's above the dose that we've outlined here, what does the patient need to do to get above that does or if there's no dose? Dr. Todd: What happens? Dr. Ellermeier: Right, so it currently says peer-to-peer but I don't know if anybody else in the committee has a different thought as to what that should look like. Dr. Porter: I think I went a little long on that topic last time. So just to be brief, I think the first contact should not involve a phone tag. I think it should be a form submitted for review by either a nurse or psychiatrist. Whatever the MCOs feels/deems adequate rather than stopping a patient from seeing their doctor because he has to be on the phone.	

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	Dr. Adma: Do you have a form for metabolic parameters right now that you use? Ms. Grant: I do have some forms we'll show later when we go to the process. What our forms look like. Dr. Ellermeier: So, I could see the challenge with that being that these are not black and white questions that would need to be asked on a form. It would be more about provide your rational for why you want above that dose. That could be on a form. I just think it would be more challenging on both ends. Like, what are you writing and then whoever is reviewing that. Dr. Porter: One of our jobs is to put our rational down on our charting in writing. We should be able to do that. I would think that if we are able to put it down rationally and who had the ability to make clinical judgments at the MCOs look at it and see it makes sense and if not. In general, your first review is in paper and; what did you call that; appeals might be on the phone. Dr. Mosier: I think that one of the things we discussed was having availability so that you wouldn't have to wait for that person when you were calling in. I know we had that discussion last time too in terms of getting that. But you've got the time taken to write it down versus the appeals process. Dr. Porter: You can write, you know, if you have a no show. Over lunch, you can do that. Where anytime you are scheduling a call, you just took a patients slot out of an already strapped mental health center or other office setting. It's guaranteed one less patient seen so you can make that call. Ms. Grant: I think the section we are talking about now is the stuff that really isn't prescribed that often. Why you don't have doses, why it's not approved, it's not used much. So I don't think we're going to get a lot of PAs on these. Dr. Porter: You know, I agree, that some of these are a lot less common. Very uncommon, this particular one. Young people getting antipsychotics or Deaconates. On the whole, with all the categories we are talking about, they start piling up and each one takes a patients slot out if it's a phone call. So I think I already went off on that the last time, so. Dr. Todd: So I guess my question, I'm sorry, is that, so, this is where I start getting kind of	

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	confused, I think this whole thing is pretty complex, what we have. So, right now we just talking about dosing limits but then there's PA criteria for some of these that are for children who are under 13, right, so that's a whole separate thing. So right now, in my mind, we already have max daily doses for adults and that's for everyone, across the board, right now, right? So, right now, we have, say whatever drug you want to pick that doesn't have the 'not approved', right now we have the max daily dose for that age range, we can change it for the other, but then we're going to have to change this other. So if it says 'not approved'. I'm just trying to figure out how we operationalize, so are we just going to override the dose part? And then it would still require a PA? Do you see the complication of…? Dr. Moeller: I see what you're saying. I think maybe that was what I was…we're saying that drug is not approved versus… Dr. Todd: Or that dose is not approved? Dr. Moeller: Or is it the drug or is it the dose? Dr. Todd: So this right here is the dose. Ms. Grant: The topic is dose, and when it rejects, it will say 'dose rejection' on it. Dr. Todd: Yeah, it will say 'quantity exceeds limit.' Right. You're taking too much. So you could have a PA approved for this member but then when the claim comes around and somebody prescribes over the dose or if we have nothing in there for these younger kids, it's just going to… Ms. Grant: I think that's normal. Drugs are denied for one reason or another. Drug interaction. Drug dose. Dr. Todd: We just want it to deny and then just have it be that someone can fill out a form and say this is why I want to…this is the justification as to why we want this member on this dose and then somebody can review it and then approve it. Is that correct? Ms. Grant: [Yes.]	

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	Dr. Todd: I just want to make sure. Dr. Moeller: I think most all of them, and I think probably most of them are the Deaconates. The only exceptions would be our two ones that have recently come out new. I guess we just have insufficient evidence. Which is the Brexpiprazole and Cariprazine. I guess we don't have the evidence. So that could be, I guess… Dr. Adma: So would your question be where it's approved for adults but now it requires a PA for the kids. Is that your question? Dr. Todd: Right. So that, right, for the dosing. I just want to…are we supposed to not give those doses or are we supposed to look at those, whatever dose the prescriber decides to submit or do we want to use…? Dr. Millhuff: I think if we've got a child psychiatrist or a board certified psychiatrist managing this it won't be an issue. Dr. Todd: Oh right. Right. Right. Right. I don't think this is going to be a big issue. I don't want you to think that. I'm just trying to think in my brain, how to tell my computer how to do this. Right? That's where I'm going with this. Just trying to operationalize it. Dr. Mosier: So you're looking at the drug, the dose, and then the age. Those three things. And you are already looking at drug and dose for adults, just adding that extra check, right? Dr. Todd: Right. Ms. Grant: I don't think it would be…right? Because you can edit age? Dr. Mosier: That's your third edit on this. Dr. Todd: And that's built into the PA. It's just going to be separate edits. So it's going to be two separate PAs.	

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	Dr. Friedebach: You know, Lisa, I think you make a good point. One of the things in operationalizing is that, one of the things we're kind of working through here is, so you've got the PA that says it's clinically appropriate but when that dose exceeds this what happens is they have a PA that the dose limit hits and it's denied, and so, taking that out, then gives you what, I think you want Dr. Porter, when you get that denial you have two options, you can do a peer-to-peer or you can appeal it in paper. And that's really driven by how the doctor feels about that. If they feel like this is not an emergency, they may do a paper appeal. They may even say it's urgent and an urgent appeal, we take care of very, very quickly, 72 hours, I think, technically. But they can go the appeal route, where they think this is very important; they could request the peer-to-peer. So the doc really drives that. So, I think you might get what the committee wants to accomplish by setting this up not as a PA but setting it up as hitting a denial. Just something to consider. Because you have PA that says clinically appropriate, but those quantity limits, that's really going to come through to the pharmacy and if it denies and they get that message and the message says, just to your point, it says denial exceeding maximum benefit or dosing limit, and then they can either appeal or peer-to-peer. So I think… Dr. Todd: Thank you. That was said a lot better. Dr. Friedebach: It took me a minute as we were thinking about how do you layer these things on top of it. I think really the PA saying clinical appropriateness and the dose limit is really just a denial. But then it comes back and you have that appeal right and the provider and kind of drive it on their schedule. Does that make sense how that would work? Dr. Ellermeier: So you're saying, basically, that the dose limit is the PA. Kind of. That's the initial review. Taking aside all the clinical PA. That's a separate piece. The dose limit is really, like, that's the initial review, and once it's over that does limit we deny automatically. So, kind of skipping that initial level and going straight to an appeal level. In which case there are different parameters about how it's reviewed. Dr. Friedebach: And it kind of makes it easier for your provider too. Because your provider knows 'I need a PA for this.' on medical necessity, but if I get over this dosing limit this [Committee] has said 'This is kind of unusual.' and that's how we kind of handle dosing limits anyway. Then they, what they would get a denial that they would respond to. So it keeps your doctors from having to	

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	think PA for medical appropriateness, PA for dosing limit. It kind of makes it a little cleaner. The other thing that we've kind of discussed is how, if you don't want to do that, how does your dosing limit then go into your medical necessity criteria? And how do you bring it all together? Which I think you may need to do one or the other. Otherwise, to Lisa's point, you're going to have two different PAs on the same drug, kind of conflicting each other and you may give the provider 'If it approves on medical necessity, but your dose is a little too high.' So, I mean, I think and then how does that adjust over time. Dr. Mosier: What do you think of that proposal? Dr. Ellermeier: It makes sense to me; the thought would be how it would be managed. Dr. Moeller: Maybe we were talking a little more in technical terms. I was getting a little confused. What are we proposing? I understood some points but then I was getting… Dr. Friedebach: Okay. So in our thoughts, you kind of look at things in two different ways. So prior authorization would be something where every doctor knows that if I'm going to prescribe this in this setting, I'm going to send justification before I even write it. And if I don't have prior authorization, it's going to deny because I didn't have prior authorization and if a prior authorization is in place, it's going to fly right through. So that's kind of one whole process you've established based on medical necessity of the care. A dose limit, in general, is saying, well once you go beyond this dose, we get a little concerned because it's outside the accepted standard of care. So do you want your doctors, when they say, well I'm going to push that dose up, do you want them to go through a prior authorization process, that we, ahead of time, before they even prescribe it, say yep, we're good for that or no we're not? Or do you want when they push that dose up, for it to deny for exceeding maximum dose limit? The benefit to doing that, in some ways, is that that becomes very concrete. They don't have to submit two different PAs on two different processes for the exact same med. Then again, it gets you out of this whole idea of Dr. Porter doesn't want a peer-to-peer; Dr. Millhuff, you may say, this is important, I want to speak to somebody today. The doc can really, in response to that denial, make the decision on what's most appropriate in that appeal. Then from the committee's standpoint, you have a prior authorization criteria that speaks to the medical necessity of the drug but you have a dosing limit that's more in line with what we do with some other dosing limits.	

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	Dr. Mosier: The question that I have would be on that having it as a denial with an appeal then what's the timeframe that they can expect a response based on the written or the peer-to-peer? Dr. Friedebach: So on an urgent or expedited, you're looking at 72 hours. Ms. Grant: With the original PA process where you get a yes or a no, that's usually done within 24 hours. If they get a denial then they would have an appeal, it can be 30 days, but if they expedite, it would 72 hours. So you actually have the PA approval/denial process first which is usually decided within 24 hours but if it's denied then they would go to appeal, and if they expedite, it's 72 hours. The original PA request is usually responded to in 24 hours. Of 'can I have this' or 'can I not', the 'yes' or 'no' of it. Dr. Friedebach: So in this case, if it wasn't a PA, they got the PA. Again, kind of think of that scenario where the doc starts the kiddo with an appropriate dose. The PA flies through, away we go. But as they push it on up, that's when, again, if they hit that denial they would never do a PA for the dose, they would get that denial. Then their appeal rights, if they wanted expedited, would be within 72 hours, and if they wanted a peer-to-peer; we set those up, basically, within 24/48 hours. We have those on our schedule. So those are quicker. Dr. Adma: So, my thinking on this is, as a community psychiatrist, when I hear from a MCO PA required, I know I need to fill in some paper work and be done. When I hear denial, most of the time, I don't know how many psychiatrists/PCPs out there would think, well, I want to appeal that denial versus appeal, I guess, provide additional documentation for a PA. I think my concern is, I think very well said, I think for the process with you said is good, but for a community psychiatrist I don't know if they are smart enough to be able to learn what a denial means, what a PA means or would do. Dr. Moeller: Now, a community psychiatrist would be exempt again, right? Dr. Adma: No, I guess, non-gold carded. On a PCP too. Dr. Moeller: I don't know how you guys deal with, if you got the word denial versus…	

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	Dr. Porter: I was just trying to think about this in a way like what would be an issue. I think we don't want to assume, I don't know about intelligence, you know, how smart, but we have a lot of different meds and a lot of different plans that we deal with. Now maybe all three of the MCOs have the same plans, that'd be great. But we still have all the, this wouldn't apply for these kids, but Medicare Part D, God knows how many plans those are, and all the different commercial plans, all of which will have separate med criteria. So I don't think we should assume the part where the clinician is going to know 'this is going to be a denial'. Here's a scenario: You get a kid. You work in a mental health center. You get a kid comes out of one of the local hospitals. He arrives, this is a 9 year old who gets to your office on 4mg of Risperdal, and they've been given enough medicine to get to the appointment. And they are doing okay on it. And you're doing all the clinical stuff. You don't have all this criteria memorized, I don't think that's going to happen. What happens, so that individual is above the dosing limit? Then they go on Friday afternoon to the clinic, what happens? Do they, it's about the dosing limit, so it's going to be a… Dr. Friedebach: I think, sadly, in some ways, to your point, if you had a PA in place, because they don't know they're beyond the dosing limit, it would deny. It's beyond the dosing limit, so it would deny. So I think the fortunate thing, in either one of those scenarios, unless your docs really know your maximum dose, they're going to have a denial either way. And it's a matter of do they have a denial for dosing limit, that tells them, 'hey, you're denied because of that' or do they have a denial for no prior authorization, which probably gives them a little less information. Dr. Todd: Then to my other point is that if we don't have a dosing range for a certain age group, then they're going to deny every time for doses, right? Or we're just going to leave it open and they can get anything. Dr. Porter: My point would be, the issue I was bringing up, I just didn't see it on this document, it's on some of the other ones, would we be maintaining that you can get a fill, like sometimes it say's 60 days. What would happen? Would that individual be able to walk away from that window with medicine and a warning that they won't get any more without going through the process? Dr. Ellermeier: I don't think with these dosing elements that we've talked about that. Like, allowing them to continue on a high dose?	

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	Dr. Porter: I would think, even in this kind of scenario I brought up, rather than a 60 or 90, even a 7 day? Dr. Ellermeier: I think we can do a 72 hour. {Several folks talking at once including elevated, whispering side conversations} Dr. Porter: I think the problem; we still don't want the individual who has been stabilized coming out of a hospital on a medicine to then go home or to a facility to be off their meds suddenly, because it's something to do with this process. Dr. Friedebach: Again, I think that if you feel really committed to that, operationally, I think you do have that option of rolling it in. I mean, you could put your dose limit right into your PA criteria. Dr. Zhou: You could build it into the clinical PA. Dr. Friedebach: If you wanted that to be considered all at one time. And then the message to the docs would be that your PA criteria has the clinical appropriateness of the diagnosis and the drug. But then also that dose limit. Dr. Porter: And your patient has been given 'x' number of days worth until you address this. Dr. Murff: If they're coded at the PBM level as a dose limit, because my concern would be if we have too many prior auths for the same drugs, those overrides are coded for that NDC, for that specific drug and strength, but if it's the 60 day override, they get 60 days, but once they run out of 60 days, once they utilize that, they don't get it again. Once they use it, the PBM is not going to know, the coding is not going to know that now it's a dose limit. Dr. Porter: I'm sorry, PBM? Dr. Murff: Our pharmacy benefit manager. The companies that actually process the claims. But if we have it coded as a dose limit, the pharmacy can go ahead and run it, they'll get that message that	

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	says exceeded the dose, they can back out the dose, dispense it without any overrides. And then once we get that, that review for the dose limit, then it goes in, the pharmacy can go back and resubmit the claim for the correct amount. I think it's safer to do it as a dose limit than to do it as a separate prior auth. Dr. Todd: Can we take the dosing limit and build it into the clinical PA so it shows one PA? Dr. Murff: I could be built into that initial prior auth criteria and still code it as a dose limit. Dr. Ellermeier: Correct me if I'm wrong, but I think we are getting too far in the weeds on how you are coding it at the PBM level, and I think our goal is to make sure that these limits seem most appropriate and what's generally used and minimizing as much disruption as we can while making sure that what's being utilized is still safe. So I don't know that we are going to be able to solve how it's operationalized. We can certainly give recommendations on that. Dr. Todd: That's just what I was trying to decide, if there's not a dosing limit, and then do we just not put any limits on, if it says 'not FDA approved' or whatever, do we just not put any limits and just leave it open? Dr. Ellermeier: No. If it says 'not approved' it should not be approved. The drug should not be approved for that age range. Dr. Todd: So they can get the clinical PA and it's approved, but they can't get the drug filled because there's no dosing. Ms. Grant: How about, we've spent one hour on this topic, how about we table it for now and come back to it? I think there's still a fair amount of disagreement on it. Dr. Moeller: I was thinking the same thing. I would move to table. Because I'd like to digest some of the stuff we've discussed. Dr. Millhuff: Just two things. Two easy things. For Abilify it is approved for Tourettes Syndrome up to 20mg in children 6 to 18 years of age. It's FDA approved at 20mg. So I recommend that we	

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	boost the Abilify from 15mg to 20mg. Ms. Grant: So even 6 years old will get 20mg. Dr. Millhuff: Correct. And that's based on FDA approval. There's just one other one on the Risperdal, Ty, if I could use that example, the Florida's guidelines list 4mg, I believe. {Several individuals speaking at the same time} Dr. Mosier: So let me go through a few things just to recap. So, what I'd like to be able to do is jumpstart the next time, so that it's a very focused conversation and we've had a really good discussion here. So, some of the things, I think, we've already decided. That I will go ahead and actually ask for a vote on the page. Is the overall age here is less than 16 in the title and the max daily dose will have the 4 years to less than 6, 6 to less than 10, 10 to less than 16, and then we'll say for reference, we have the adult dosage. I will ask for a voice vote, starting with Dr. Klingler. Dr. Klinger: Yes. Dr. Porter: Yes. Dr. Moeller: Yes. Dr. Millhuff: Yes. Dr. Ellermeier: Yes. Dr. Adma: Yes Dr. Mosier: Okay. Unanimous. Alright, so we've got that piece. We did have a question on the table of the use of Decanoates add all or separate them out. Was there a consensus on whether or not? Dr. Ellermeier: I think we agreed to remove them from the younger age. Yes, remove them and only apply them for adults, so not approved.	

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	Dr. Millhuff: Adults starting at 16. Dr. Adma: All Decanoates. Dr. Millhuff: Are adult guidelines limits have16? Ms. Grant: I'm sorry; I was trying to switch my screens. What did you say to me? Dr. Ellermeier: You already have the Abilify Maintenna. But, then the adult dosing limits will need to then reflect the change down to 16. Ms. Grant: Ok, so, so, ok so just put… Dr. Moeller: Though, do the guidelines only apply to 16? Does it make a difference? Ms. Grant: Should it say over 16 instead of adults? I'm not sure. Dr. Ellermeier: Yes. Dr. Mosier: So 16 and above? Ms. Grant: Oh, I did that in the wrong direction. Dr. Mosier: Annette and I were just discussing a few items. So, on the operational questions, where did we land so far? Dr. Todd: I'm sorry, I muddied the waters. Dr. Mosier: So, we're at muddy waters, okay. So we'll take that. Dr. Friedebach: Do you want us to kind of summarize the option and send it out to the committee on what the doctor would experience and you guys can think it through?	

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	Dr. Millhuff: Yes, that would be nice. Dr. Porter: I guess if the committee is still, if there's a differentiation between the experience of one provider or another, I think that needs to be clear. So in other words if there's a gold card idea that's more solid for the board certification guy has one experience and the nurse practitioner has a different experience I would like for that to be clear. Dr. Mosier: It actually is part of how we set this up is if you…all of these gold carding applies and so unless you as a committee determine that everyone should be under these guidelines, for this criteria. Ms. Grant: It was talked about last time, 4 and under nobody got the gold card I think. That was the discussion last time. Dr. Mosier: That would be added to the criteria, if otherwise, it's consistent across all. Dr. Porter: Ok. Dr. Adma: Then one more thing I want to add is Loxapine in the list. It says not FDA approved, I would recommend that because we do see a lot of kids with developmental disabilities on this medication… Dr. Moeller: I used to see it a lot. Dr. Adma: I would say maybe put 30mg for 6-10 years and 60mg for 10-16 years as a dose range. Chip, unless you have any additional thoughts on that. Dr. Moeller: That sounds like an appropriate. That's very conservative. Dr. Adma: Loxapine at 30 and 60. Dr. Mosier: So why don't I go thru the dosing changes that I understand here and then we'll also	

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	just vote on that and we can have that piece addressed this time. Dr. Millhuff: Are we voting on this part you just mentioned, about no gold card for less than 6? Dr. Mosier: No… Dr. Millhuff: Ok, you just made that… Dr. Mosier: No there was not an age, I wasn't talking about that. Dr. Ellermeier: I think that was for a different criteria we talked about that last time, I think. Dr. Mosier: It was if at any time you wanted to not have gold carding in effect, but my understanding is… Ms. Grant: Oh, that was on the criteria. I apologize. That's the next one. Dr. Klingler: That's the next. Dr. Moeller: I would prefer voting on the dose, the top ranges maybe at the next meeting because I feel like we're making all these last minute adjustments. I would feel more comfortable if we were to review a little again. We're routing the Loxapine, we're just changed the Abilify, there's still things I feel that we're rushing through. Like do we still even need Compazine on there? We don't have anything for the 12-18 but we're prescribing for the 6-12. I think we need to consider, like we're taking out the non FDA approved, but I would prefer to table it. Dr. Mosier: We'll leave the rest of it till next time. Dr. Moeller: I would propose to table it to next time. Dr. Mosier: Is there anything else that hasn't been reiterated here at the end that needs to be included?	

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	Dr. Millhuff: If we're going to table it till the next time it would be nice to see the version that we've come up with, not a week before next meeting, but it takes a lot of time. Ms. Grant: Yes, as soon as she gets it done. Dr. Moeller: I would like to be able to come in and pretty much vote, or limit discussion for 15 minutes. If we're going to keep Compazine then we need to come up with a dose for 12 to 18. Ms. Grant: So, I'll update it and send it out to you, would you guys all reply on some of those areas of inconsistency? Then, like, I believe we need to take out the starting doses on a couple of those because we couldn't operationalize it. I'll get that to you and if you'll get it back to me. Dr. Mosier: I recommend what we do, in addition to sending out the table, highlight anything that's been changed and discussed, but then also have it in a summary form so that you could just read through, kind of have it both ways so that we're calling out what we've discussed, what's up for review the whole table but specifically it will call out discussion items for your special intention. Dr. Ellermeier: The other thing that I would like to see and I realize it could be somewhat of a challenge but would be to see how many members would be impacted above these limits. Once you've emailed it out and heard back feedback we would then get data to see how many members are we talking about. I realize you may not be able to look at that data with the gold card status or not but just to see number of impacted number of members within each category. Ms. Grant: Within the new age groups? Dr. Ellermeier: Within the new age groups, yes. Dr. Mosier: Any other issues to address on this? Alright so, this one is tabled to next time. I think we discussed kind of paired with that was number 3. So we will consider these together next time? Ms. Grant: Okay.	

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	Dr. Mosier: As I understand it. Is that correct, Annette? Ms. Grant: I was thinking 3 was the criteria which we kind of pretty much really mulled over last time. Dr. Mosier: Number 2 is the criteria on the agenda. Dr. Ellermeier: So, I think number 3 we need to change the age to 16. Dr. Mosier: That's the only change I guess we're comfortable with the greater than 16, I guess we'll consider that one today. Dr. Moeller: Yeah, we already just voted on… Dr. Mosier: So we're comfortable with this. So we're moving to 3 then we'll go back to 2.	
II. Old Business B. Prior Authorization Criteria 2. Antipsychotics for <18 years old Criteria Review and Title Change	Dr. Mosier: And this was, as I understand it Annette, these captured the discussion and changes. **Clinical Public Comment: -** No requests were received. **Committee Discussion:** Ms. Grant: From the last committee, basically the age changes which now I guess we may need to discuss to change them again that we changed the dosing now that I see that. Last time we talked about the different diagnosis's, changed it to Mood Disorder, Psychotic Disorder, Tic Disorder, Tourette's, and Autism Spectrum Disorder. Took off the waist circumference in number 3. We added the documents from the Texas program the red bullets, 1, 2, and 3 that are kind of like make sure you have the social factors in place and training and that suggested in there. I apologize, I'm going to go back, but under 4 there was a question of peer-to-peer consult or else do you want must be prescribed by psychiatrist, neurologist or developmental behavior pediatrician. Do you prefer line A or line B? Dr. Ellermeier: Could it be both, like an 'or'?	Dr. Porter moved to accept the criteria as amended. Dr. Millhuff seconded the motion. The criteria were approved as amended unanimously.

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: That's a good point. Dr. Ellermeier: Rather than meeting both of them they just have to meet one of the two? Dr. Millhuff: I think that's fine. Dr. Ellermeier: That makes sense to me. Dr. Adma? Dr. Adma: Yes, I'm fine. Dr. Ellermeier: Then it would be instead of; must meet all the following, would be; must meet one of the following? Right above that? Ms. Grant: Okay. Dr. Mosier: Let's see….which….am I looking at the right document? It's all. Dr. Ellermeier: She just opted it. Rather than striking it and not only doing this top one do either of those two. Dr. Mosier: That was my confusion. Last time we struck it. I thought you were down on the line under criteria for prior auth. Ms. Grant: And then I said I apologize I should go back to that very first line. So I apologize. So we're going to do or, we're going to keep both lines. The new and the old. Dr. Ellermeier: It makes sense to me that it's either to a psychiatrist, neurologist or developmental behavior pediatrician or there's some way that's not necessarily easy referral but some way for a different type of practitioner. Dr. Mosier: Well this was less than 4. We had the long discussion about this last time. Dr. Klingler: I think the less than 4 that was our intention that is shouldn't be anyone other than	

	DISCUSSION	DECISION AND/OR ACTION
	those 3 people. Dr. Ellermeier: Even with a peer to peer through the medical director? No? Dr. Klingler: Under 4 if the child needs it they need to be seeing a psychiatrist, I would say, I think our intention was very purposeful on that last time and should be left. Dr. Moeller: So, I agree. Ms. Grant: Are we all happy with that part then? Must be prescribed only by. Dr. Mosier: So then you have in highlighted in yellow the ages, and we've agreed to the less than 4 the four years to less than 6. Ms. Grant: Which probably we need to change now because we've changed it on the other documents. Dr. Mosier: Not the 4 to less than 6, we're fine. So, must be prescribed by or in consultation/collaboration with the psychiatrist, neurologist, or developmental pediatrician. So for 4 to less than 6 then we have the choice there and that's what we wanted to distinguish that. Then you see the changes with the Tourette's, Autism Spectrum Disorder, fasting glucose, weight and height but we took out waist circumference, made it previous 6 months, then when we go to the next page. Dr. Moeller: We don't have the documentation with the 4. Dr. Adma: Less than 4 right? Dr. Moeller: Now, I'm just noticing, we don't have documentation, fasting blood glucose. So you see? Dr. Mosier: Oh we don't have those criteria. Dr. Moeller: We don't have the age criteria.	

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: For under 4 we don't have those? Dr. Moeller: For under 4 we only have that it must be prescribed but we're not requiring them to have a fasting plasma glucose, lipid screening, and weight. Dr. Adma: Diagnosis. So we should include these 2 points. Ms. Grant: So add those criteria? Is that what you're saying, Karen? Dr. Moeller: Yes. We're saying the real young people we're not. He just said it. Dr. Porter: Who knows? This is so uncommon, who even knows what this would mean in that age but we're better to require it. Dr. Moeller: We're better to require it then not. Do they need to have their diagnosis? I don't even know what the diagnosis is for under 4, but, Okay. Dr. Adma: One of those would be fine. Dr. Porter: I don't mean to throw things too far off but for the longest time within all of the members of this committee we had not run across… none of us in our history knew of a case of one of these kids that was two on an antipsychotic. We had them from the MCO caseload. But I did run across one and it was a child who is now 12 or 13. They had been placed I think on Risperdal around age one or under two for incessantly hitting/striking their head against a wall or something like that and it apparently helped. I'm just not suggesting that's great; I just hadn't run across a case until now. Dr. Millhuff: I just want to say practically speaking as someone said doing a fasting blood glucose on some of these kids if they are that out of control it is very difficult. I mean it means like going to the papoose for it. And I mean… Dr. Moeller: But I think we kind of interpreted in these criteria if they refuse or…	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Ellermeier: It was… it was like the doctor was at least trying… writing for that to happen and whether it happened or not was another story. At least attempting… Dr. Millhuff: You mean like the order has been written? Dr. Ellermeier: Right. Dr. Moeller: That was on that sheet of paper that we were supposed to have. Dr. Klingler: I am trying to figure out how you are supposed to interpret this. Ordering a test because we are ordering a test without how we are going to interpret that is and when you have to draw labs on a combative toddler it sounds like an easy practical thing to do; it is not easy or practical. Dr. Millhuff: Nor is it for many of these kids in these. Dr. Ellermeier: Right but isn't it still part of the practice guidelines that these things should be happening in kids? So whether they are happening or not there should still be an attempt to like be monitoring. This not just be ignored. Dr. Porter: The infants. Dr. Klingler: That is under four. So what guidelines are you going to use to interpret those and what decision point are you going to make once you get those labs back? I mean if you are not going to act on that information then why are you gathering it? Dr. Moeller: Would you not act on that information? Dr. Klinger: What guidelines are you going to use to act on? When would you say your threshold was for discontinuing it? I don't know if there are… Dr. Moeller: I don't know like…	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Porter: Sugar. Maybe lipids. Dr. Klingler: Yeah…I… Dr. Moeller: That is what I meant. Dr. Klingler: I don't know what… Dr. Moeller: If you saw an abnormal. Ms. Grant: If there sugars high their mood would be whacked out so that would be a whole different diagnosis altogether. Dr. Millhuff: But rarely when it comes to that sort of medical assessment of their labs if there is something a little bit weird I am going to be calling you. Dr. Klingler: Yeah. Dr. Millhuff: And saying based on your physical exam and other features do you think this something you think we need to worry about. You are looking at not just the labs, you are looking at a more global assessment. Dr. Klingler: Right. We will look at a global assessment but what… Dr. Moeller: I remember when we first discussed this back maybe over a year and a half ago it was because we even talked about the… I don't even know our age ranges in saying that we would have these difficulties and kids not wanting to get blood draws and things and that was supposed to be on the documentation that you fill out that you attempted to get the blood sugar, fasting lipids. I would hope you would at least… I would hope as a physician you would at least… you know, you get a baseline weight you know 20 kilograms and then if they gain or maybe that is a little too much but you know they gain in access you know… in a month later they have gained you know 10 pounds that would be significant and you might be concerned of the…	

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: So overall we are ok with adding this then? Dr. Adma: I agree with you, Rebecca, in terms of you know there is one thing about both us saying you know there needs to be a psychiatrist involved or a neurologist involved in prescribing them. Maybe it needs to be a diagnosis that fits what we usually use for. Again subjecting 2 ½ or 3 year old to all the labs; I don't know what purpose it would serve. At least if it is clinically indicated then do it. Dr. Porter: I guess this is a… are there… there are accepted ranges of lipids and blood sugar in a 3 year old? Dr. Klingler: But they are not done routinely they are done on kids with pathology that you would be concerned about those things. Heart patients, metabolic patients. So it's not something that is done regularly. Dr. Porter: But there are normals? Dr. Moeller: These should be very minimal patients again, too. Dr. Ellermeier: But I… Dr. Moeller: We are at least trying to. Dr. Ellermeier: I think part of it is you want to know what their baseline is. If you are starting them on this medication at 2 or 3 you need to know what's the baseline so when they are 7 or 8 how far as that… were they abnormal to being with before you started them on these medications or is it an effect of the medication but not even attempting a baseline level? I get it will be a challenge in younger kids. But I think just ignoring it all together doesn't make sense to me either. Dr. Klingler: Baseline screening on pediatrics for lipids starts at 11. Ms. Grant: Would you like to take out the lipids then being part of that?	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Klingler: I would probably defer to Chip on… Dr. Millhuff: I think it is a more complicated decision that what we are going to be able to execute in the mechanism that we are using. You are looking at other variables such as the child's BMI, family history, other factors that are risk factors and just to say let's just do the lab just so that it is done… I mean there are some people I will follow the lab more frequently on based on these various risk factors and others that I won't follow as frequent and I am following directly the recommendation of the academy on that sort of thing. So there is the art of this practice that is kind of getting lost in this that we're trying to define. Dr. Mosier: We have in some criteria said something to that effect of following the recommendations of the academy; do we want to change it to something along that line? Dr. Porter: I don't think they have them for this age though. Dr. Millhuff: But that is kind of what the academy does in their treatment guidelines is they'll just say follow general recommendations and they will commonly reference that ADA guideline which was done in concert with the APA and that just call it good. I want to read something that will take just a second here… in this is the practice parameter for the use of a typical psychotic medication is children, adolescents. It says ideally monitoring a BMI, blood pressure, fasting blood glucose and fasting lipids should follow whenever feasible. Recommendations found in the consensus statement put forth by the American Diabetic Diabetes Association and the American Psychiatric Association although clinicians should recognize some patients may have difficulties with transportation, time constraints if in school and parental work schedules. Regular monitoring is still important to follow children adolescents. They kind of want to leave it vague; they don't say do baseline three months, six months, year; it doesn't get to that specificity so I am thinking we might want to kind of follow suit but in using good clinical judgment and reference kind of from a general thing. Dr. Klingler: Maybe the compromise on that is recommended to do these things rather than documentation of… because we would like to encourage people to do them. But, recognizing it's not always feasible.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Millhuff: In my understanding at present for all of these PAs on this age range using this current existing criteria if you don't have the lab work done it is getting rejected. Dr. Porter: Right. Dr. Millhuff: So it's not… Dr. Ellermeier: We talked about it. Dr. Moeller: So if a child refuses; we document it. We talked about a form about 18 months ago and so you wouldn't have to call in… he has this diagnosis. Ms. Grant: Hopefully we can get to that form, but I'm not sure, it's already 3:30. Dr. Todd: I'm sorry, but operationally like if we have on there, which I think in some of the other criteria we are denying it if there's not the documentation, because it says it must meet the following and it says documentation of blah, blah, blah. So, if those aren't there. Dr. Adma: Then that can be… Dr. Todd: So if we change the wording. Dr. Ellermeier: What if its documentation in that this has been attempted or has been ordered and not that it has been completed. Dr. Todd: Right so we just need to change the wording. Dr. Ellermeier: I don't think any of us thought the intent is that they would get rejected if they weren't being done because of all of the challenges we talked about. Dr. Moeller: Yes. Dr. Todd: We just covered it the way it was written and approved.	

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	Dr. Ellermeier: I am disappointed based on our conversation that that is happening. Dr. Millhuff: I think that we should say leave it more as a recommendation and you have attempted; you've written an order, for instance. Dr. Moeller: An attempt or order. Dr. Porter: Is this across all child and adolescent or just under four? Dr. Millhuff: I think it should basically line up for any pediatric. They should all be the same. Why would they be different? I agree, yeah. The only other thing I would add is the length of approval; I would suggest we consider 12 months. Dr. Porter: Even on the youngest? Dr. Millhuff: Even on the youngest. I would put 12 months on all of these. Again I am getting back to the idea that we are putting the bumpers kind of wider and I am also basing that on a lot of feedback that I am getting specifically about this PA. It is a 30 minute process every time you have to work on it. It is very time consuming. Dr. Porter: Are you are talking the length of approval or the length of… Dr. Millhuff: The length of approval and the length of review which is further down. {Individuals talking over each other} Dr. Porter: You can still recommend 6 months if you want too. Dr. Millhuff: Right. Dr. Klingler: Especially in that age group you want to monitor.	

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	Dr. Millhuff: You are going to be seeing these kinds of kids every three months. Ideally, you should not be going more than 6 months. Ms. Grant: So is less than four correct then? Dr. Ellermeier: Yes. I think four is if you scroll further down on four to six there are a couple more criteria and I don't know if the intent is to match them or not. Dr. Zhou: Quick question on the less than four. We used to have the peer-to-peer consultations so if it's not a neurologist or a psychiatrist or pediatrician are we not approving it? Dr. Moeller: That is what we decided; they need too… they need to be referred. Dr. Zhou: Okay. Dr. Porter: That is a really good question. I don't know the scenario I'm not trying to be chicken little about this but what if there is some in this great state of ours some case out in the corner somewhere where a kid needs one of these things and it can't be managed directly by one of these individuals; I may be inventing a scenario would we want to be impossible to get it changed? Several speaking at the same time: They would have an appeal right Dr. Porter: They retain an appeal right? Dr. Zhou: Yes. Dr. Moeller: I think Dalt, right? Recommended to use the same terminology, we used a book. Ms. Grant: That's right. I was just thinking to myself what… Dr. Moeller: Documentation of attempt… Ms. Grant: Thank you, it's like you were reading my mind.	

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	Dr. Moeller: Or 'attempting'. Dr. Millhuff: Also I am not really good with my, Autism Spectrum Disorder is what the title is in the diagnosis, with capitols. Ms. Grant: Ok. I can fix that stuff later. So if we go four to six years consult/collaboration, same diagnosis code, lab work within 12 months here is that what we are wanting here? Dr. Ellermeier: No. Ms. Grant: Or leave that six months? Dr. Porter: Yes but the approval is 12 months. Ms. Grant: Okay and the three items that were from the Texas document that we wanted some kind of behavioral management, documentation, follow-up. So that should be good on that one? Correct? Dr. Ellermeier: Can you scroll down sorry I want to read those a little more carefully considering our discussion about the labs. Dr. Porter: The fifth bullet point is, of course a good idea, the questioning came up about what level of documentation are the MCO's going to require? Ms. Grant: I imagine some; just something that, I don't know. Maybe when we discuss processes or forms or something we can discuss that. Dr. Porter: That would be part of it. Dr. Millhuff: Nicole, just what you said before could we attest to that? Yes I think it should be an attestation and not chart notes. Like just a check box on a form.	

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	Dr. Adma: You might want to date that, Annette. Dr. Todd: I know from like our standpoint I don't know about the others we change these into kind of yes or no questions so if but will all of the lab values and stuff we always just have.., Dr. Adma: Have they been done? Dr. Todd: Yeah, have they been done? We don't gather… Dr. Ellermeier: I think it should be attempted for all of these things. I think there are scenarios like: this is best practice but I think you could probably think of a scenario where it is not happening. Dr. Adma: Another thing I see here is evaluating of family functioning what if they are in foster care? Dr. Klingler: I'm not sure about evaluation Dr. Mosier: That it's that family; that foster care family. Dr. Adma: So I might want to at least have something in there that explains that. That they're not the family. Dr. Porter: The third one makes so much sense when you say in the child's record, the kids move so much. Their records don't always go with them. Dr. Millhuff: I took that specifically from the Texas guidelines. Dr. Porter: Yes, it does make sense. Dr. Millhuff: But you know… Ms. Grant: It should be in this document somewhere; we should be writing down any part of writing down of anything then how do you know it is being done and that the child is really being taken care	

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	of properly? Dr. Porter: That's true. Dr. Klingler: I think that becomes even more important with kids in foster care just because that's the scenario. They come into our office on four or five medications; what are you taking this for but nobody knows and somewhere we've got to be able to track down that documentation and get them appropriate mental health. Ms. Grant: So, are we good from 4 to less than 6? Dr. Ellermeier: Do we want less than 4 to match? Dr. Millhuff: It would make complete sense to me. Ms. Grant: Less than 10 is that what we want to change it too? Dr. Mosier: No, where we have it's less than 4 and then its 4 and less than 6. Dr. Ellermeier: It is all the same bullets Dr. Klingler and Dr. Moeller: Put those Texas bullets under the less than 4 too. Ms. Grant: The attestation too, that part? Dr. Millhuff: It's just the idea particular with early childhood the use of these medicines; you're trying everything before you get to that point. I can even see that as kind of being an education tool to some ways. Ms. Grant: Are we good to move to the next age bracket? A request was to instead of keep doing the different years just go 6 to less than 18. Dr. Mosier: 6 to less than 16?	

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: And now would be 6 to less than 16, yes. Dr. Moeller: One time when I said you know for the age ranges, I still like to make sure that the less than 18 are getting their fasting and all these things. I would rather keep it, I would still like the 18 but I'm not… Dr. Ellermeier: Yes I think your point earlier was their pharmacokinetics are starting to act more like an adult as far as the drug but there's still some things that. Dr. Porter: There a minor, somebody's their guardian. Dr. Moeller: I think that we need to drive down some of these things to. I would keep it 18. My recommendation but unless someone has some good. Dr. Ellermeier: I agree but I don't feel strongly either way. Dr. Adma: I look at it is consistency; put it at 16 and then it would be consistent with everything else. But, I'm ok either way. Dr. Moeller: I guess, yeah, if it is procedurally we are creating; because with adults we don't have any of these like fasting lipids or anything do we? Dr. Porter: We don't have this criteria, they are all recommended. Dr. Moeller: Yes we only have like multiple so. Dr. Porter: I think probably because on this one and maybe it goes back to the other one that we tabled some of these folks are wards of that state at this age and someone else is their guardian which is a different thing than an adult even though physiologically they are very similar to let's say a 19 year old so I don't know. I wonder if we shouldn't keep the stricture monitoring recommendation 18 and under. I don't know under 18 would actually be the answer because 18 is an adult.	

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	Dr. Adma: That's a good point. Dr. Moeller: But dosing I think we're… Dr. Adma: Especially kids in foster care for example. Dr. Moeller: An issue with I think 18… Dr. Adma: Are we changing that to 18 then? Ms. Grant: You want it 18 then? Dr. Moeller: Yes. Dr. Adma: Yes. Dr. Porter: Yes and then 16 and 17 year olds would still for the reasons we discussed still have the recommended criteria to monitor. Dr. Adma: Operationally will this be a problem or no? Ms. Grant: So do you want documentation of attempted gathering of fasting or recommended? Dr. Moeller: I think we can still say the same. I mean we even have 50 year olds who refuse blood draws. I think it is as long as we are attempting. Ms. Grant: And an attestation to on the next one? Dr. Adma: Yes. Dr. Mosier: Going back to the second bullet point we have are we going to go ahead with the 12 Months? We have 3, 6 and 12 as choices.	

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: Which do we want? Dr. Mosier: Or you can add something in between. Dr. Ellermeier: Let's do 8. {Laughter} Dr. Porter: Let's do 6 months. Dr. Millhuff: I would like it to be 12. We have tons many, many kids that are never getting their labs done-period and I just want to… Dr. Ellermeier: We are just attesting anyway that we tried… Dr. Millhuff: That's true. Dr. Ellermeier: I think 12. Dr. Porter: Put it 30 and lower but then… Dr. Moeller: What the guidelines typically say is you get a baseline and then you get a fast for glucose you get a baseline and then at 12 weeks and then yearly so I even for the younger you know 6 months if we gave them an approval of 12 you know… do we want yearly I mean it's just that secondary that three month point we're missing. But lipids don't need to be monitored as frequently. Ms. Grant: So 12 months is ok then? Dr. Ellermeier: I think 12 months is fine. Ms. Grant: So the information as a whole; 6 to less than 18, 12 months?	

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	Dr. Millhuff: I would just want to say one of the things we need to consider to try psychotherapy or other interventions first sometimes you have a crisis presentation and there's and it is indicated because they are psychotic or their manic and you're not going to hold off on medicines before you are going to treat that; I mean would you, Vishal, hold off? Dr. Mosier: You want to say 'when clinically indicated' or something? Dr. Millhuff: Yeah, I think so. {Several individuals speaking at the same time} Dr. Mosier: When clinically indicated. It can be at the end or however you want to phrase it. Dr. Ellermeier: It gave me a little heartburn the way it was worded. Dr. Millhuff: It's kind of strict for preschooler's is the way I was thinking when I wrote that. I didn't want; if we could loosen it up a little bit when you get would be good. Two individuals at once: Older. Dr. Millhuff: Older, but a child psychiatrist should be thinking of a developmentally appropriate assessment even if it is an adolescent. Dr. Porter: If you had to just that most scenarios mentioned if you said appropriate emergency management or something that would, those types of emergency settings would need that would meet that criteria also. Dr. Millhuff: Correct. Dr. Mosier: How do we want to phrase that, capture that? Ms. Grant: So is this good then from 6 to less than 18?	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Porter: I don't know how that last sentence flows when clinically indicated would seem like it needs. Dr. Ellermeier: I think it needs more… Dr. Mosier: More of the emergency… Dr. Porter: I think it needs flushed out or put somewhere different. Dr. Mosier: Call out the emergency piece instead. Dr. Ellermeier: Maybe non-psychopharmacological interventions have been initiated when appropriate before psychopharmacological? Dr. Porter: Even an emergency non-psychopharmacological process are initiated, we're trying to be nice to the person. Help them calm down. Ms. Grant: And this is a 6 to less than 18, so that's a pretty big range there. Dr. Porter: We can word it any way, but maybe something that's a little looser. That allows for emergency treatment without it running into it. Dr. Adma: So how would the MCOs operationalize this? Do you have a check box to ask for it? Dr. Ellermeier: I feel like if we're going to ask for them to say 'yes' or 'no', and they say 'no', they're going to say well it's denied because, this is really, like, what does it mean for them. Ms. Grant: When clinically indicated and also emergency situations. Dr. Porter: Maybe that's it. Ms. Grant: Because we have 6 to less than 18 and that's a big range.	

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	Dr. Adma: So Chip, what do you think about us just saying, non-psychopharmacological have been attempted? Dr. Ellermeier: That's what I was just thinking. Dr. Millhuff: Have been attempted and maintained if clinically indicated. Because sometimes these kids get really stable on these meds. They just need the supportive process of meeting with you and contacts and it's sufficient. Ms. Grant: Have been attempted…what was the rest, Dr. Millhuff? Have been attempted and… Dr. Millhuff: 'and maintained if clinically indicated.' Ms. Grant: Clinically, what was the work? My brain kind of just shut for a little bit. Dr. Millhuff: When you get done with that one, what do you guys think about the bullet right above it saying 'Patient assessment to include DSM-5 diagnosis(es)' and then right after that, plan, or something, I mean, 'screening for parental'…it's more of a statement of what's good practice rather than a requirement. You're not always going to have collateral information. So you can make attempts or, I don't know, just remove the whole last part. Dr. Porter: You always want the DSM-5 diagnoses. You always need that. Ms. Grant: You have bullet 3 which kind of says bullet 4 in some ways, you've documented this is all appropriate, so do you want to get rid of 4 altogether? Is everybody in agreement with that? Dr. Klingler: I think for that age group that would be appropriate. Dr. Porter: Then you could add the DSM-5 diagnoses to the end of bullet point 3. Because that has to do with the assessment, right? Ms. Grant: Okay, so we're good? The last thing on it is renewal criteria. Basically the thought process is if they've done all these things before hand and been monitored appropriately, then	

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	renewal criteria would just be, the labs. What are your thoughts on that? Dr. Moeller: Change it to 12 months? Dr. Ellermeier: I think it's 12 months and I think it's 'attempted'. Ms. Grant: Okay. Dr. Moeller: The same wording, 'documentation…' Dr. Porter: These documents are coming together nicely. I wanted to through one other thing out there for my colleagues, should there be anything about movement, about AIMS, if we're being safe with this population. Dr. Moeller: Probably, if they've got Haldol and all of those. Dr. Millhuff: [inaudible][01:55:45], every visit. Dr. Porter: I know we just went through these, but there's other things besides lipids that are concerns with this class of medicine. Dr. Millhuff: I'd rather just keep it simple. As simple as we can make it. But I agree, that's good practice. Dr. Adma: Yeah, good practice, but requiring them… Dr. Porter: Can I go back to that one more thing for my colleagues, one of the functions we have with this is educational. This is a reminder to all of us to keep these metabolic things in mind and I do think, especially with the atypicals, we can tend to get a little cavalier about the movement disorder. A risk with atypical antipsychotic medicines. Because it seems better than typicals for sure. But, I'll just throw that out there. It would add complexity. But we could make it pretty loose at least to just to put some reminder. Just because it's Abilify, doesn't mean you shouldn't check for it.	

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	Dr. Moeller: Couldn't we just put it in that bullet 3? I mean, I agree. Dr. Millhuff: Bullet 2? Dr. Moeller: Or bullet 2, documentation of attempted, we have many things, plasma glucose, lipid screening, weight, height, and AIMS. AIMS is Abnormal Involuntary Movement Scale. Dr. Ellermeier: I think it should just be added to that bullet. Dr. Moeller: I think, yeah. Dr. Millhuff: That's fine. Dr. Moeller: And I think 12 month is Dr. Porter: I really think we should be doing that. Dr. Adma: I think, again, there's a difference between 'attempted to' and requiring. Dr. Porter: At least we're reminding people about it, an educational piece. Dr. Klingler: Do we need to spell it out rather than use the acronym? Since this is going to be a document on medical. Dr. Moeller: Abnormal Involuntary Movement Scale. And then I would recommend putting in the 4 year old, the 6 year old. Dr. Porter: I should have brought that up earlier. Ms. Grant: That's an easy fix. Dr. Moeller: I think it's very important.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Ellermeier: Under renewal as well. Dr. Millhuff: That used to be a requirement for every Topeka State Hospital admission. Dr. Adma: We do it at our hospital at admission. Dr. Mosier: I was trying to look in the minutes, but there are seventy-five pages, so I can't find the discussion from last time, so I'm just going to ask the question; Some of the things we originally had in the renewal criteria include an annual physical. Do we still want to include 'annual physical'? Dr. Ellermeier: I think we talked about removing that but I don't remember the specific discussion around it. Dr. Mosier: Obviously if you're attempting to order lab, you're… Dr. Ellermeier: I think it's assumed they're being seen. Dr. Adma: A psychiatrist might order labs too. Dr. Ellermeier: But they won't do the full child check. Dr. Mosier: 'Annual physical must be completed by a pediatrician, family practice physician, nurse practitioner, or physicians assistant for continued approval' Dr. Millhuff: I think that makes good clinical sense, but keeping the bumpers out we think of them also of why, particularly in thinking of our kids particular in the foster care system that are moving around the state. I know it might be difficult for me to know whether or not they've had a physical exam in the last year, and also some of the families—they don't comply very good. Do we want to stop their antipsychotic medicine based on not having a physical exam? Dr. Mosier: That was the discussion that …	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Klingler: Isn't an annual physical exam required for their renewal? Dr. Adma: For school—right? Dr. Klingler: Not for school; only if you change districts. It is required for sports. It is required for every single foster care placement. So those kids actually get caught up on those probably quicker than kids in their biologic home. Ms. Grant: So, are we good? Should we start at the top [inaudible][02:00:00] Dr. Mosier: So do you want to chew on that and then take that up at the next meeting or do you want to go through it and then talk about it and approve it, or no? Dr. Millhuff: This is going to be easier to get through… Dr. Ellermeier: Today. Dr. Millhuff: Now. I mean, easier for prescribers if we get going on this. Dr. Moeller: I agree. Dr. Ellermeier: We'll restart the discussion next time. Dr. Mosier: That's true. Ms. Grant: So 16 and younger is good? Dr. Millhuff: Or didn't we go to 18? Dr. Moeller: Maybe we need to change that to 18. Ms. Grant: Well alright…I actually think we've mulled this over. I don't think we've missed anything.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Porter: So it will be under 18? Not 18 and under? Ms. Grant: 18 and younger or under 18… Dr. Porter: Under 18. People that aren't legally adults. Dr. Klingler: Under 18—yes, that looks better. Ms. Grant: So I've got AIMS on each one of them. Tell me if I'm going too fast. Dr. Millhuff: I'm just going to say… Dr. Mosier: Do we have on the 3rd bullet—sorry—there's 6 months. Did we change that to 12 months? Dr. Moeller: We did not change it on the 4 to 6, although I don't have a problem being consistent, because we changed the approval to 12 months, so … Dr. Porter: And I don't think you… you can't really actually do an AIMS can you on a five year old? Dr. Millhuff: I wouldn't. Dr. Porter: At least not on a 3 year old because they won't follow the instructions right. Ms. Grant: Do you want me to take it out or leave it? Dr. Mosier: This is on the 4 to less than 6. Dr. Ellermeier: I think they should all be 12 months for consistency and the fact that… Dr. Moeller: I agree. 12 months -- so even the less than 4 should be 12 months.	

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: Okay, but what about the AIMS? {People talking over each other} Dr. Moeller: If a kid can't do it, then… Dr. Millhuff: Yes, that's fine. Ms Grant: So, 12 months here. Dr. Millhuff: Yes. Ms.Grant: Okay, so, less than 4; 4 to 6… Dr. Mosier: Spelling—on the top bullet point there, "last autism" – the spelling of "autism." Ms. Grant: So, are we good? Dr. Adma: Yes. Dr. Mosier: Okay, do we have someone to move for approval? Dr. Porter: Move for approval. Dr. Millhuff: Second. Dr. Ellermeier: Do we have to vote? Dr. Mosier: We can do voice vote. {All committee members said "Yes." individually}	

	DISCUSSION	DECISION AND/OR ACTION
	Alright, approved.	
II. Old Business B. Prior Authorization Criteria 3. Antipsychotics - Adult Title Change ≥18 years old	Dr. Mosier: But, the adult antipsychotic dosing limits of rather than having it say adult then the greater than, greater than or equal to 16 or 16 and older. I'll put that. We'll take a vote on that. Dr. Klingler? **Clinical Public Comment: -** No requests were received. **Committee Discussion:** Dr. Klingler: I was just making sure the two were congruent. Ms. Grant: Ok. So greater than or equal to 16 to adult. Is that the new title for this one? Dr. Ellermeier: Older than 16. Dr. Mosier: Oh no, it's 16 and older, right? Dr. Ellermeier: Including adults, not 'to adults'. Dr. Mosier: So, 16 and older Antipsychotic Dosing Limits. Dr. Porter: I can see that the lists are a slightly different length and trying to figure out which one doesn't belong. On the adult ones and the antipsychotics. I'm sure it's in there. Dr. Moeller: Well, what I see on the 13 is they have like Paliperidone and then they have another line for Paliperidone palmitate that they included. Dr. Porter: I knew it was in there. I just couldn't… Dr. Moeller: They have like the Deaconate. Dr. Porter: Gotcha. I see.	Dr. Moeller moved to accept the criteria as amended. Dr. Ellermeier seconded the motion. The criteria were approved unanimously.

	DISCUSSION	DECISION AND/OR ACTION
	Ms. Grant: So this is how you voted on last time. Name change, title change on this one. Dr. Moeller: I'm in favor. Yes Dr. Ellermeier: I will second it. {All committee members voice their approval at one time} Ms. Arace: Who moved? Dr. Moeller: I did. Ms. Arace: Who seconded? Dr. Millhuff: Nicole. Ms. Arace: Thank you. Dr. Mosier: Good. So this one is approved. Let's go back to 2 for the criteria then.	
II. Old Business B. Prior Authorization Criteria 4. Opioid Dependence Agents- Review request by DUR	Dr. Mosier: And one more on old business. And this came back from the DUR with one small request for change is my understanding so I'll let Annette go through that. **Clinical Public Comment: -** No requests were received. **Committee Discussion:** Ms. Grant: Okay, so we're almost there. Instead of "not ordered by the same prescriber" they would like it to be "In consult with the Suboxone prescriber." Dr. Ellermeier: So rather than "if not ordered," "if not in consultation"? Dr. Moeller: What do they want? I'm confused.	Dr. Ellermeier moved to accept the criteria as amended. Dr. Moeller seconded the motion. The criteria were approved as amended unanimously.

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Ellermeier: Rather than "If not ordered by same prescriber," "if not in consultation with the Suboxone prescriber." Dr. Porter: The point is their awareness of it. Dr. Ellermeier: Yes. Dr. Moeller: Do we want to use the word Suboxone or do we want Buprenorphine? Dr. Ellermeier: Because there are a couple of different products now. Dr. Moeller: Suboxone, Subutex. Dr. Ellermeier: So rather than "by," "in consultation." Ms. Grant: Is that good? Dr. Ellermeier: I think its "If not in consultation." Dr. Moeller: How do they document that? That's going to go for a PA, right? And they can say, "Yes, I consulted him." Do we require documentation from the Suboxone prescriber? Dr. Ellermeier: I think the Suboxone prescriber is the one filling out this PA form, so they would have to be aware of the benzo. Dr. Moeller: Okay. Dr. Adma: So what they are saying is, I guess, Suboxone prescriber is the only person who can prescribe a benzodiazepine—that's what they are saying. Dr. Ellermeier: That's what we were saying. What they're saying is, another prescriber can prescribe the benzo as long as the Suboxone prescriber knows about it.	

	DISCUSSION	DECISION AND/OR ACTION
	Dr. Moeller: So the Suboxone person—or sorry, the buprenorphine prescriber, if I'm getting it correct from Nicole, they're going to be the one filling this out. So, it's going to be rejected—which one? The benzo or the buprenorphine? Or is it either? Because then it could be the PC [inaudible]. Dr. Ellermeier: The Suboxone will deny for a PA initially. They'll fill out a form to get it to begin with. And I would imagine that they'll have to put whether or not the patient is on a benzo to allow the benzo to close. Dr. Moeller: Oh, okay, I forgot about this, it's a …So that's what the DUR board… Dr. Adma: So they're saying: if somebody else can prescribe benzo, then I can prescribe Suboxone? Dr. Porter: As long as you know about it… Ms. Grant: Their scenario was that you're stuck in western Kansas, and so that was where it came from… You know what I'm saying? If you don't have access to everyone in the same place, or whatever, then we need to give them that flexibility of being in consult with. Dr. Adma: Any information on the data on this, as well as… Ms Grant: Yes, that was the one that had 55 members had both; half of them were by different prescribers. Pain management plus PCP. Dr. Adma: How are the MCOs handling it in other states on this issue? Is this a struggle in other states? Dr. Zhou: We're seeing this… Potentially, we did talk about Suboxone and opioids and how the opioids reject when there is a Suboxone claim, but we never had any issue dealing with benzodiazepines. Dr. Adma: No other state has this issue?	

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	Dr. Zhou: Not to our knowledge. Ms. Grant: We do have 55 patients on both and there is a risk of death. I think we've approved this over and over again. Dr. Moeller: Yes. Ms. Grant: I'm hoping this is the final. Dr. Moeller: The DUR keeps sending it back. Dr. Adma: So what we're saying is the benzos claim is denied for 30 days after Suboxone fill if not in consultation with the provider. I think it's a compromise, so. Dr. Ellermeier: I move to accept this. Dr. Moeller: Second. {All committee members said "Yes." individually}	
II. Old Business C. Preferred Prescriber Status 1. PA Process-Smart PAs and Consistent Processes	Dr. Mosier: So I know one of the reasons we changed this to the afternoon was so that we would have a little more time. Specifically we wanted to look at mental health medication claim prior authorization processing today in terms of process. I'm going to propose something here. We have these others here, which should be fairly quick in terms of the PDL additions. We're scheduled to 4:30. I want to give a half hour to the process if you want to go a half hour, if you'd be willing to stay and do the rest of it. Dr. Klingler: I will have to go at 4:30, but that's just me. {Committee members discuss staying late} Dr. Mosier: Okay, so we will stay. If you'll go to the process, Annette. **Clinical Public Comment: -** No requests were received.	For informational purpose only.

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	Committee Discussion: Ms. Grant: Okay, so, currently, as you know, we do it manual. All the states I heard back from also are doing this manually. The different PBMs have different abilities to operationalize different pieces of this. To find ways to be more consistent where they're doing the same thing. Which is what the Legislature would like. It takes time to for each PBM to code their system. I'm working on this for another issue and it is a very long process. The one I've been working on for something else has taken 8 months. So trying to operationalize this and make it a non-manual form is very difficult for the MCOs and Fee for Service to get that all done consistently. The MCOs, their systems do look back for age/drug history. And if, on the medical side, if there's a diagnosis put in on the claim, then it can read that. That also matters if it's in proper order when it reads the claim. So I know that you'd like it to be at point of sale and electronic but it's difficult and that's why other states are still doing manual too. It's just a very difficult process. I did bring you some copies of the PA form that we have for you to see what they look like. Ours and a couple other states. We could look at using maybe some kind of the same form for all of this, it would just have a different logo at the top. There's some pros and cons to that as well. I'll let the MCOs talk about that a little bit and go from there. So let's just look at and see what our state one looks like. If you guys are gold card you won't know what they look like, so just to give you an idea, the one on screen. This is was criteria before we just changed it, it's the current criteria. Go to the next one; this is the basic patient information. Then you see the 'prescription is written in consultation with' and it gives you a box. So really, it's a check box system. So not too difficult to fill those out and fax it in. Here's diagnosis and the labs and then the renewal. Of course we just made renewal way simpler. So after you get past the first hurdle, from then on it's good. But then it's so good that we are so thorough when their first getting this, the safety factor there. So this is what our state one looks like. Dr. Moeller: This is all on paper? Do they have computers? Ms. Grant: All paper. To try to code labs or some of these things in the PBM systems it's just… Like I said, I'm working on that for some other issue and it's going to be at least 8 months before I get through a very simple complication. So it's very difficult for them to code their system to go along and read how we'd like it to read. Dr. Adma: 'Hyperactive behavior', did we take that out?	

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	Ms. Grant: Yes. This is the old one. We just changed it. It will look different after this. Dr. Adma: Okay. Ms. Grant: So this is the Massachusetts form. I do have Texas form with me. Which resembles the same thing. Patient information, the drug, previous medications. This is actually a four page form. So, quite long. But it may be that it's, they might have more conditions. Dr. Porter: The Massachusetts one also includes a Step Therapy component. Dr. Moeller: I can see that if their requesting an ODT, you know, why this dosing form. Dr. Porter: Which we haven't got to yet, as far as this committee. There is a plan to is my understanding. Dr. Mosier: Step Therapy doesn't come through here as far as this group. Dr. Porter: It is not? Ms. Grant: So, anyway, so this one's a pretty lengthy form, but it's pretty thorough. Dr. Mosier: Oh, wait. I'm sorry. I misspoke. It does come through here. Yes. Dr. Porter: Because that was the more recent law that we're going to get to… Dr. Mosier: Yes. Sorry about that. Ms. Grant: So anyway, so this is what Massachusetts looks like. And then, I have Texas. And this form for Texas is… I kind of like it. It kind of goes long. They have part of it through a smart PA, but not all of it. So this would be like the steps: Less than 3 years old? Yes--denied. No—go to number 2. History of substance abuse? This is an ADHD imminent release formulation. This is just an example of a PA form that I pulled. But I liked how this flowed. Denied—go to 4. So, I don't	

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	know, if we want to look at when we use it if we possibly condensed all of the MCOs to one form. We could go to the checkboxes but we could also do, maybe a speedier form; I'm not sure if this is possible. But this is what one of the Texas PA forms look like. This is a simple document, though. This is just IR formulations. It's not like the criteria we're talking about. This is just an ADHD drug IR authorization PA. Dr. Zhou: And this looks like an internal document they might use to determine whether something is approved or denied, so it's not really for the provider office—this form? Ms. Grant: Right, it's for you guys internally to look at, because I think you were talking about if our MCOs all had the same document to go through the PA process on, it would be faster and easier for you guys, if you had some kind of form like this to use when you're processing them. Dr. Porter: I get your point…whoever's filling this out would still have to have information from the provider in order to check these boxes. And that would need to be a different form, hopefully— Dr. Todd: And I think some of ours is auto-loaded into, you know, if somebody does it all electronically, then its auto loaded then to those yes/no questions, you know, even from a form like when it's faxed it. So somebody wouldn't have to sit there and click the boxes. Ms. Grant: But… so those are just some samples of forms. I don't know, back to the questions on what do we do, and I think it is manual. I don't think at this point we can make it other than that because it's very cumbersome to try to get all the MCOs to be able to process it. It's just—I don't know of a way. Dr. Porter: You know, the one problem about a checkbox for the—no, there's two different things if I'm right. There's one which is the metabolic screening we're looking at in young people, which we've never suggested would go to a peer-to-peer. We've always suggested that would be information provided to the MCO. And the separate thing would be on the age and dose limits and other things that, right now, this will read "Contact that the peer-to-peer with the MCO." So, what I mean to say is, that's going to be hard to do with a checkbox—that thing. Because I think if you're going to place, I've been suggesting the initial contact with, from a phone call to a form, you're going to need to be able to explain on that form essentially what you might say to a psychiatrist at	

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	the MCO. You know, "Why do you think this dose that's higher than this is a good idea?" And I think you're going to need freehand. Dr. Ellermeier: I agree. I think that, when possible, it should be checkboxes for the criteria, but other times you're just not going to be able to do that, and you'll have to leave freeform space for prescribers to write something. I would even argue when you're doing one that's just checkboxes, if they have some additional information, you still leave them space to add that. Dr. Klingler: This form just represents that they've met the criteria that we just put forth, it doesn't really give the clinical rationale anywhere. I think that's what [?] is asking for. Ms. Grant: On the Kansas one? Dr. Klingler: Yes. Dr. Porter: So you have two different things. One is just how to show you've met the criteria and the other is asking for something outside of the criteria. Dr. Millhuff: Besides this one that we just reviewed today—I keep trying to remember—do we have any others like this? Ms. Grant: All our forms are set up like this. Dr. Millhuff: But I mean— Ms. Grant: Different criteria/information, but they're all in a checkbox system like this. Dr. Klingler: So, walk me through…. So, this gets filled out…. Ms. Grant: This is what you print off if you got a PA, you go online and print this off, and then fill it out, and you would fax it to the number that the pharmacy will tell you that you need to fax it to. Dr. Klingler: And then what happens from there?	

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	Ms. Grant: The MCO would receive it, and then they would review it, and I'll let the MCOs talk about that part, if you would. Like I know Angie reviews them mainly herself. Dr. Zhou: Not these, but the PBM does. So, the PBM has a pharmacist who—well initially, it goes to the technician, and then it goes to the pharmacist, and they will review whether all the criteria are met. If they are met, then they will go ahead and approve it. If not, then they send it back. Dr. Klingler: So they don't need any clinical rationale as long as those checkboxes are met, they'll approve it? Ms. Grant: I didn't bring all the forms, but I'm sure some of them will have that on there. Dr. Klingler: That's what I was getting at—is this the one step for the clinician, or then it goes through your process, and then more information is requested… How do we get as much information as you need to make a good determination without having to have the physician go through multiple steps now, and then in two days give you more information, and then in two days give you more information? Dr. Zhou: And I think this committee should kind of determine what kind of information we should really be requesting. Do we need to request anything clinical? Anything written? Or do we just say, well, okay, you checked the boxes—that's enough due diligence. Dr. Moeller: I think it's going to be more when you go above the max. Like, right now, this is just allowing. Dr. Klingler: Right. Dr. Millhuff: Yes, I think we should keep it simple on the allowing aspect. Dr. Moeller: I think this looks… to me it looks fine. I mean except with all our changes. Dr. Millhuff: Because, right now, don't you have to fill out not only—you're going to have to fill	

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	out patient and provider demographics on these forms? Dr. Zhou: Yes, you should still have that box. Dr. Millhuff: But then the current forms require drug history and other information as well, from what I understand. Dr. Zhou: Yes, I think the PBMs have different forms. Dr. Todd: Our forms are different. Dr. Murff: Well, and just a clarification: UnitedHealthcare doesn't really use a PBM. We have a clinical team. Dr. Todd: I don't think we really require drug history. In fact, if a physician actually calls us, then we actually send the form back and the prescriber information is printed on that, so you don't have to put that in. Dr. Ellermeier: Is the patient demographic also included if they call in to get a form generated? Dr. Todd: It is. Yes. That's right. Dr. Ellermeier: Okay. That was a question I had. Dr. Todd: That was that third step, and that's what we do internally. I don't know about if we move to a custom form, I don't know if that—I'll have to find out if we can have that serviced, or it may have to go back to everyone filling it out manually. Dr. Millhuff: So it seems to like, however this mechanism works to—how, in terms of time, what is a reasonable amount of time that you think we can boost this to in terms of the turnaround in getting approval? Dr. Todd: Ours is 24 hours. We turn it around in 24.	

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	Dr. Millhuff: Oh, I meant, just for the person, whether it's your assistant or the physician—whatever—how, in terms of getting it filled out and turned in, I guess? Dr. Ellermeier: Are you guys all currently asking consistent questions? I realize the forms may look different, but are the questions for each criteria consistent today? Dr. Todd: My forms (I'll say what mine are)-- mine are literally your/these criteria and we have check-boxes for each of those criteria so the physician knows what the criteria is and gives you that—you know, whether be checkboxes it—maybe yes/no. They're answering the yes/no questions. Ms. Grant: Just like this: Is the patient receiving evidence-based behavioral modification? Did they get their annual exam? It's the criteria with a box saying yes or no. Dr. Ellermeier: Yes, but I can see how these questions could be asked multiple different ways. So, I think it would be important, not so much that the form is identical between the MCOs, but the questions are. Dr. Todd: That's why at least we chose to—we left it exactly off of how its worded, except for we will change it into "Has the member met this criteria?" or "Has this…" but we take that language and we don't even flip words around or anything. So, we try to stay as consistent to that State criteria as possible. Dr. Adma: And your forms are similar to theirs or different? Dr. Zhou: Not right now. Dr. Adma: They're different? Okay. So do you see benefit in coming up with one form for all three MCOs that you all agree on that maybe collectively can use? Dr. Zhou: I think it would be okay to have one form except that I don't really like the idea of different cover pages because you can get mixed up within the doctor's office—you send the form with the wrong cover page. That's the only worry I have.	

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	Dr. Ellermeier: Yes, to me it seems like maybe there should be more collaboration on developing the questions on the form and not so much that the form is exactly identical, because, I agree—if they are all identical, I can see it being really easy to fax to the wrong MCO because they all look the same and you're used to faxing one to… So I think my thought is it's more important that those questions be asked the same way. Dr. Zhou: We can definitely get together and create similar forms with similar questions. Dr. Adma: Not that I'm creating more work for the docs, here on this form I see that the glucose/lipid screening and all is being asked. So, it's only a checkbox, but if the lipids are really high? Dr. Ellermeier: Well, we haven't asked that question on the criteria. Dr. Adma: Sure. So there's always that [inaudible, then laughter]. Dr. Porter: Hopefully we'll all be good doctors [if that happens]. Dr. Millhuff: Well, the other thing that I'm worried about is a hard-stop at the pharmacy and someone abruptly not getting their medicine filled. What do we have to protect against that? Ms. Grant: They always have that 3-day override. They can get a 3-day supply of their medicine, so they shouldn't be without medicine. Dr. Porter: It does depend on the drug class a little bit. But I'll say that this whole thing got started off under the auspices of safety. And most of the time… --ADD meds maybe might not be such a big deal in a way, but most of the other things, the risk of health issues from drug-stop is greater at that point in time than any of these metabolic things we're looking at. What I mean would be, nothing is going to happen much with your glucose or lipids in three days and you can have a horrible situation if you're not allowed meds. Ms. Grant: Which is good why we changed that. So, now that we treat the original criteria, then, we	

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	won't have hard stops. Dr. Porter: I know you said 3 days? Dr. Mosier: I think it's 5 days. Dr. Porter: Five? Dr. Mosier: Yes. Dr. Porter: That's better. I can still come up with a scenario where it's Wednesday before Thanksgiving and the clinic, you know. Ms. Grant: But, I guess at some point we have to be—I mean… 3 days is a pretty good amount to finally get things squared away. Dr. Todd: It gets you over the weekend— Dr. Porter: Unless it's Wednesday before a 3-day weekend, and then you've got the turnaround time of the actual review, whatever that is—one to three days? Dr. Todd: So, it's kind of overlapping. So, let's say the pharmacist receives the prescription, they send the claim in, it rejects—does a hard-stop--says "This drug requires a PA." Dr. Porter: Right. Dr. Todd: Right, so then they call you and say, "Hey, we need to get a PA started." That's when the physician calls in and starts that PA--that's when that 24-hour turnaround starts—right, but in the meantime, the pharmacist can go, talking to the physician when they call, the physician can go, "Yes, but the member needs the med now." So, then the pharmacist can put in an override code, and the claim will pay for them for a 3-day supply. Dr. Porter: There's just a lot of moving parts to the scenario for people to stay on meds, and if any	

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	of you have ever tried to take meds regularly, you know there are things that can happen. In any case, the patient doesn't go straight over to the pharmacy, or their appointment is at 4 p.m. and they get to the pharmacy at 6 on Friday. You know the clock is ticking. And, again, this helps patients. It also helps MCOs because bad things that—A) you guys want the best for your members, and B) you know, you're missing your antipsychotic or even going off your antidepressant and having a discontinuation syndrome, can cause you to go to the emergency room or worse. So I really would ask you guys, just for the outliers—those weird situations—that Thanksgiving weekend which is really 4 days you can't reach your outpatient provider, that you consider a longer period of time that you cover waiting for this—at least a week. Dr. Ellermeier: For this one though, aren't we allowing 60 days? Dr. Moeller: That's what I thought, I thought-- because we just went through it, they have 60 days. Dr. Zhou: I thought we were talking about global mental health… Dr. Millhuff: 60 days is a one-time shot. Dr. Ellermeier: Right, they get 60 days one time. So then they have time to get their PA in. Dr. Porter: That's fine. 60 days is fine. I just was hearing about 3 days. Dr. Moeller: Well, each criteria we have has different things, so like this one has—this one we just went through and voted on, it all had 60 day overrides. Now I think [inaudible due to overlapping voices] if it's not specified, so there's dosing limits. So, like Risperidone 5-mg, that 9-year down on Risperidone 5-mg would have…. Dr. Porter: Well that will be a smaller group. Dr. Ellermeier: Would have 3 days, and then, in theory, the pharmacy could bill for lower dose. Dr. Porter: Everything would still be—true--but it would be a much smaller group of people affected, but it would still be a big effect if everything else had happened that way.	

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	Dr. Adma: So about this PA form, Nicole are you suggesting that maybe all the three MCOs get together to come up with questions that would make sense and then figure it out, and then maybe presenting it for the committee, and maybe a form they're happy with, and we can look at with you? Dr. Ellermeier: I think it's less important that the form look exactly identical for a couple of reasons. There are internal processes to get that all generated. Then also for provider confusion. If they need to know 'where am I sending this form?' and every single form looks the same, I can see that adding confusion. But I think it's really more about how the questions are asked, and making sure that that is what is consistent. So, I don't… Dr. Adma: Then bring that form, whatever they agree on, to the committee? Ms. Grant: They could bring a couple versions. Then take a vote on which you prefer. Dr. Ellermeier: Or perhaps when we're talking through a criteria, like, once we've done the initial and it's supposed to come back for a final review, we then see the questions that the MCOs are proposing at that time. Ms. Grant: Okay. Dr. Adma: And then, I also see on this, auto PA functions. So right now, it's all manual? Ms. Grant: Right. There's some with ages and background drugs, but the whole form is not. Dr. Todd: I guess I didn't answer that question earlier. Actually at Amerigroup you can file an electronic PA. It's not an auto PA. You can do the whole thing electronically. Without talking to anyone. And approved, right there on the spot. Dr. Adma: And then, what is Auto PA? There's electronic PA. What is an Auto PA? Dr. Todd: An Auto PA is a 'look back' in the actual claim itself. So, if these mental health drugs would be too complex to apply, let's say like it's a drug, you know what I'm thinking of like, Retin	

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	A Cream, a topical retinoid. I think our age limit is 18 years old or something like that, 18 and above, so our claim system; and would have the diagnosis of acne or some specific diagnosis, so it will go back…the claim will come in, the claim will say 'oh, yeah, this drug requires PA'. But then the claims system itself will go back and pull out of medical data that's been supplied by your office, for like an office visit, and look at diagnosis codes that had been submitted on medical claims and then, obviously, just look at the age and eligibility window and see if those check boxes match. And if they do, it sails through and it just pays. No one even knows, the pharmacist doesn't know, that it required PA, the physician didn't know. It just automatically approves. But it's pretty simple criteria. These mental health drugs wouldn't apply at this point. Dr. Adma: Okay. Dr. Millhuff: Lisa, you talk about the 72 hour override, that's a Medicaid standard. {Ms. Grant and Dr. Todd speaking at the same time} Dr. Mosier: We'll look at the statute, because I recall two years ago when we had discussion of extending it for mental health purposes, when we were running the bill, there may be a State statute that extended it for mental health medication. So we'll look into that and clarify that for the group. Dr. Millhuff: I've been in situations, for instance, where I've got somebody in a rural setting. They have a stimulate prescription. The pharmacist needs a paper prescription and I can't physically give it to them. I've had some push back, like I can not give them a short 3 day supply, unless it's a dire emergency. Is that the same kind of scenario you're talking about? Dr. Todd: If it's a Schedule 2 drug so that's going to… Dr. Millhuff: So that same sort of standard would not apply to these drugs? {Sounds, no verbal response for or against the previous question} Dr. Millhuff: And most pharmacies, in general, do all pharmacies know to apply this 72 hour override?	

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	Dr. Todd: Honestly, I think we could probably do a better job of advertising or educating our providers and reminding them. I think that would be a good education piece. I mean it's a rule. I've known about it for a long time when I worked retail but that doesn't mean everybody is going to know. Ms. Grant: In regards to your… if you sign up to e-scriber you could send that electronically over to the pharmacy versus paper. Dr. Moeller: You can send electronically, but you have to meet some secure standards. Ms. Grant: You have to sign up for it, but then you can… Dr. Porter: And their pharmacy has to be… Dr. Moeller: But you know what I think the pharmacy has to be signed up. Dr. Ellermeier: Most of them are. Dr. Millhuff: What we've experienced though is pharmacies that aren't utilizing the mechanism right. So we've got our patients going without and falling apart. So, is there any way that this committee could safeguard that that doesn't happen? I just don't want my patients abruptly stopped on their antipsychotics. It isn't safe. Dr. Ellermeier: The antipsychotics shouldn't fall into that same issue, because they're not Schedule 2. That's why the pharmacy won't dispense the 72… Dr. Todd: I think maybe you're saying that, correct me if I'm wrong, I think maybe you're suggesting that if the pharmacist, that specific pharmacist is not aware of the 72 hour rule, then they think 'I don't have an approval so I can't fill it.' And they just wait. Dr. Millhuff: And then they just drop the scenario right there. Then we find out later they've been without their medicine. Those are the kind of examples.	

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	Dr. Todd: I think that sounds like a real education piece. You know, like a gap, that we could really try to from the MCO and the Fee for Service standpoint, we could really reach out to our pharmacy providers and re-remind them of the 72 hour and then if it's five days in the rig or such, or the 68 for this we could talk about this. Dr. Millhuff: So the feedback I got from child psychiatrists and prescribers throughout the state specifically focused on this 13 and under. They didn't complain so much about the others, but it's about two things common to all, is 30 minutes for each one, and then people going without their meds. Dr. Friedebach: Dr. Millhuff, can I ask you, did you say psychiatrists? Dr. Millhuff: Psychiatrists. Dr. Friedebach: Are giving that feedback? Dr. Millhuff: Giving that feedback to me. Dr, Friedebach: Do you think the gold card is not, maybe we're not getting? Dr. Millhuff: Psychiatrists and non-psychiatrists. Some of the psychiatrists reply to me about their colleagues. And medical directors and such that these are such major problems. Dr. Todd: Nurse practitioners too. Dr. Friedebach: We may need to understand just where's that coming from, specifically. Just to see… Ms. Grant: We will address that subject at a later time as far as who all is on the gold card. Dr. Millhuff: Great, because the other thing is in the mental health centers the other thing that I'm hearing is that people not within the mental health center settings aren't, they're stopping taking	

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	people that are going to require these atypical antipsychotics-kids-and therefore the load is getting greater upon the mental health centers. And we're already stretch very thin. So I just want to bring that feedback, as a representative of the community mental health centers, and what we're facing because of these specific atypical antipsychotics. I think today we've made some changes that will ease this a little bit. But I wanted to get that in before this meeting got over. Ms. Grant: We'll come back with some forms. I think our criteria will help with what you're talking about. Dr. Ellermeier: Can I ask that the forms be sent out ahead of time and not the day of the meeting? Hopefully we can provide feedback through email rather than editing here at the meeting. Dr. Millhuff: I did want to say that Annette did a very nice job of dialoging back and forth since out last meeting. So I encourage anyone that wants to do that, she's very responsive. Dr. Mosier: Thank you. Thank you all for staying we are now in overtime, officially. Not like the Patriots. Sorry for those who are Falcons fans. {Laughter}	
III. New Business A. Mental Health Medication PDL Class Additions 1. TCA Class 2. SNRI Class 3. SSRI Class 4. ADHD Class a. Prior Authorization Criteria	Dr. Mosier: We just have a few more items, so, Annette, I'll just turn this over to you again. **Clinical Public Comment: -** No requests were received. **Committee Discussion:** Ms. Grant: Okay. So, there are four classes that have already as a committee have gone through and approved criteria on that I would like to place on the PDL. What that means is that we can manage them from a financial position. The PDL committee itself, reviews all the clinical on these before they will actually allow it to be on the PDL. What I'm basically asking is for approval to place on the PDL. All our boarder states have these on and have had them on, so this is not new to surrounding states, just to Kansas. Dr. Adma: So PDL is 'Prescriber Drug List' or…?	The committee agreed to combine all items under *New Business* and vote on all four at once. Dr. Ellermeier moved to accept. Dr. Millhuff seconded the motion. All Mental Health Medication PDL Class Additions were

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	Ms. Grant: Preferred Drug List. Dr. Adma: Preferred Drug List, okay. Ms. Grant: They go in by classes. Dr. Porter: There's five orphan anti-depressants that aren't on this list. Ms. Grant: What I did was take the list of drugs from a previous that you already approved. Dr. Porter: What I mean is like, there's some that aren't on here because they don't fit into any of these categories. Does that matter? Dr. Ellermeier: It's just by classes. Ms. Grant: Right. Dr. Porter: There's some that are the only one of their type. Ms. Grant: We can add to this list if you'd like to. I do have the last item on each: ' Future drugs new to the market under this drug class- Approved for addition to the PDL without needing presentation to MHMAC members first.' Dr. Porter: I'm not sure how important it is, but there are some that won't fit into these categories. Ms. Grant: Right, and we'll address those at a later time. Dr. Porter: Okay. Ms. Grant: The PDL is by class and so…I see what you're saying, but these are just the first 4. Dr. Porter: Okay.	approved unanimously.

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	Ms. Grant: And mainly because you've already approved these groups. And, so, I wanted to start with what you already have. Dr. Ellermeier: Doctor, maybe we need to clarify, the PDL is not like the formulary, those drugs are still covered, this is just a separate list, and this is the preferred and non-preferred. Dr. Porter: Okay. Ms. Grant: I apologize if I didn't make it clear. Dr. Porter: It could be me following and not following. Ms. Grant: So the Tricyclic is the first. And again, these all go to the PDL first for approval and then the go to the DUR. Dr. Ellermeier: So we're the first step in that process? Ms. Grant: You're the first step in that process. Any mental health drug will come here first. With the exception of the last item I put on each; if there's a drug that comes out, specifically comes out in a certain drug class, like SNRIs, if there's a new one, I would automatically add it to the list to take to the PDL. And that is my request today. 'Future drugs new to the market under this drug class- Approved for addition to the PDL without needing presentation to MHMAC members first.' Meaning it would go immediately to the PDL committee to approve. Dr. Adma: So we have to approve these, I guess? Ms. Grant: Yes. All 4 classes to approve so I can take them to the PDL. Dr. Adma: I don't have a problem with any of these lists. Dr. Mosier: Do you want to just take them all and vote on at the same time?	

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	Dr. Adma: Yes. {All committee members responded 'Yes.' individually} Dr. Mosier: Okay, Approved.	
IV. Open Public Comment*	None	
V. Adjourn	Dr. Mosier: Anything else anyone wants to bring up before we adjourn? Dr. Moeller: I'll motion to adjourn. {Several other committee members offer to motion to adjourn as well.} {Several committee members seconded the motion.} Dr. Mosier: Alright. We are adjourned. Thank you very much. Sec. Mosier adjourned the February 14, 2017 Mental Health Medication Advisory Committee meeting at 4:38pm.	Several Committee members motioned to adjourn. Several Committee members seconded the motion. The motion to adjourn was approved unanimously.
*Clinical and open public comment requests and written testimony must be submitted one week prior to meeting to Annette.Grant@ks.gov. If providing clinical comment, please indicate which agenda item you are requesting time to comment. Time limits during period of comment will be determined based on number of requests received. The next MHMAC meeting is scheduled for May 9, 2017.		